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The National Committee for Mental Hygiene

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The National Committee for Mental Hygiene and its affiliated state societies and committees are organized to work for the conservation of mental health; to help prevent nervous and mental disorders and mental defect; to help raise the standards of care and treatment for those suffering from any of these disorders or mental defect; to secure and disseminate reliable information on these subjects and also on mental factors involved in problems related to industry, education, delinquency, dependency, and the like; to aid ex-service men disabled in the war; to coöperate with federal, state, and local agencies and with officials and with public and private agencies whose work is in any way related to that of a society or committee for mental hygiene. Though methods vary, these organizations seek to accomplish their purposes by means of education, encouraging psychiatric social service, conducting surveys, promoting legislation, and through coöperation with the many agencies whose work touches at one point or another the field of mental hygiene.

When one considers the large groups of people who may be benefited by organized work in mental hygiene, the importance of the movement at once becomes apparent. Such work is not only for the mentally disordered and those suffering from mental defect, but for all those who, through mental causes, are unable so to adjust themselves to their environment as to live happy and efficient lives.

QUARTERLY MAGAZINE
OF
THE NATIONAL COMMITTEE FOR MENTAL HYGIENE, INC.
370 SEVENTH AVENUE, NEW YORK CITY

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MENTAL HYGIENE

ORIGINAL CONTRIBUTIONS

January

	PAGE
Some Problems of Disabled Ex-Service Men Three Years After the Armistice, by Thomas W. Salmon, M.D.	1–10
The Status of "Clinical" Psychology, by F. L. Wells, Ph.D.	11–22
The Care of Neuropsychiatric Disabilities Among Ex-Service Men, by Douglas A. Thom, M.D., and H. Douglas Singer, M.D.	23–38
Influence of Affective Disturbances on Responses to the Stanford-Binet Test, by Stephen Perham Jewett, M.D., and Phyllis Blanchard, Ph.D.	39–56
State Care, Training, and Education of Mental Defectives, by Pearce Bailey, M.D.	57–67
Laziness in School Children, by Ira S. Wile, M.D.	68–82
Crossbreeding of Ideas as a Factor in Invention, by Thomas H. Haines, M.D.	83–92
The Personal Psychiatric History, by Lila Kline	93–124
Case Correspondence: a Method of Psychiatric Social Work, by Elizabeth C. Hayes.	125–155
The Specialist; a Poem, by Martha Haskell Clark	156

April

The Place of Mental Hygiene in the Public Health Movement, by Haven Emerson, M.D.	225–233
The Patient and His Attitude Toward His Neurosis, by Douglas A. Thom, M.D.	234–247
Psychiatry, Psychology, Psychologists, Psychiatrists, by William Healy, M.D.	248–256
The Next Step in the Mental Hygiene Movement, by Charles P. Emerson, M.D.	257–262
Nervousness: Its Cause and Prevention, by Austen Fox Riggs, M.D.	263–287
The Social Significance of Dementia Praecox, by Edith M. Furbush	288–299
Mental Health and the Newspaper, by Nelson Antrim Crawford	300–305
A Social-Service Department in a State Hospital, by Marie L. Donohoe	306–311
Psychiatric Social Work in a Red Cross Chapter, by Margaret Worch	312–331
One Hundred Institutionally Trained Male Defectives in the Community Under Supervision, by Mabel A. Matthews	332–342
Three Hundred Psychiatric Examinations Made at the Women's Day Court, New York City, by Augusta Scott, M.D.	343–369
A Contribution to the Mental Pathology of Races in the United States, by Pearce Bailey, M.D.	370–391

ORIGINAL CONTRIBUTIONS

JULY

PAGE

Some Aspects of Mental Hygiene, by E. Farquhar Buzzard, M.D., F.R.C.P. 449–462

Habit Clinics for Children of the Pre-School Age, by Douglas A. Thom, M.D. 463–470

The Inauguration of a State-Wide Public-School Mental Clinic in Massachusetts, by Walter E. Fernald, M.D. 471–486

Personality in the Mental Defective, With a Method for its Evaluation, by Harold W. Potter, M.D. 487–497

Some of the Psychological Mechanisms of Human Conduct, by Irving J. Sands, M.D., and Phyllis Blanchard, Ph.D. 498–521

Internal Secretions and the Home, by Earl D. Bond, M.D. 522–525

The Problem of the Mental Misfit in Industry, by George K. Pratt, M.D. . . 526–538

The Psychiatric Work of the New York Probation and Protective Association, by Anne T. Bingham, M.D. 539–574

A Social Analysis of a Group of Psychoneurotic Ex-Service Men, by Grace Massonneau. 575–591

Personnel Relations in State Hospitals, by Horatio M. Pollock, Ph.D. 592–597

Incidence of Insanity Among Jews, by Jacob A. Goldberg, M.D. 598–602

The Study of Individuality, by Charles E. Nixon, M.Sc., M.D., Ph.D. . . . 603–606

OCTOBER

Body and Mind: the Origin of Dualism, by Sir Frederick Mott, K.B.E., M.D., F.R.S. 673–687

Mental Hygiene Needs Arising Subsequent to School Life, by C. Floyd Haviland, M.D. 688–699

Psychology in Medicine, by F. L. Wells, Ph.D. 700–707

The Importance of a Special Educational Training for Mental Defect Dependent Upon Organic Lesions, by L. Pierce Clark, M.D. 708–713

Results and Future Opportunities in the Field of Clinics, Social Service, and Parole, by Douglas A. Thom, M.D. 714–728

A Study in Constitutional Psychopathic Inferiority, by John W. Visher, M.D. 729–745

The Child and the Home: an Extract from a Survey of Mental Health Conditions in a Metropolitan District, by Marianna Taylor, M.D. . . . 746–772

Child Mental Hygiene in Erie County, New York, by Aaron J. Rosanoff, M.D. 773–797

The Social-Service Department and its Relation to an Extensive Parole System, by Harry A. Steckel, M.D. 798–814

Alcoholic Psychoses Before and After Prohibition, by Horatio M. Pollock, Ph.D. 815–825

The Sanatorium; a Poem, by Susanne Howe 826

The Pioneer; a Poem, by Arthur Guiterman 826

MENTAL HYGIENE

VOL. VI JANUARY, 1922 No. 1

SOME PROBLEMS OF DISABLED EX-SERVICE MEN THREE YEARS AFTER THE ARMISTICE*

THOMAS W. SALMON, M.D.

Medical Advisor, The National Committee for Mental Hygiene

DURING the week in which this date[1] fell three years ago, fighting in the Argonne was at its height. Our battle deaths alone were nearly a thousand a day—the heaviest of any week in the war. Base hospitals of the A. E. F. were crowded to their capacity. In most of those in forward areas full "crisis expansion" of tentage was required to receive the stream of wounded men pouring in from the divisions at the front. Two of those great hospital centers could have cared for all the ex-service men who are under treatment in hospitals in this country to-day, yet two such centers constituted scarcely a tenth of the hospital facilities in use. A feeling of deepest concern for the men in these hospitals existed in every household in the United States in which a service flag or a Red Cross poster was displayed. The doctors and nurses who were the instruments by which this mighty volume of sentiment was expressed in France were fully conscious of the sacredness of the trust reposed in them. There was no distinction between "worthy" and "unworthy" soldiers. Diseases and injuries that ended military usefulness forever were treated as carefully and as skillfully as wounds or disorders that could be cured in time to restore fighting men to the line. Complicated conditions called only for an extra output of energy and skill and although, even at that time, many men were suffering from disorders that will terminate

* Read at the American Red Cross Convention, Columbus, Ohio, October 5, 1921.

1 See note above.

only many years hence, the terms "chronic", "custodial", "terminal", and "incurable" had not yet found places in our vocabulary.

The Interval (1918-1921)

Although to-day the war seems far off, it is well to remember that there are ex-service men who have spent the three years since it closed in bed. These men have been aware, above them, of clashing of authority and wrangling over precedence, but they have seen about them the devotion of individual doctors and nurses, making atonement in makeshift hospitals for the deplorable delay of Congress in appropriating money for real hospitals and the equally deplorable efforts of a three-headed administrative anomaly to act as if it were directed by a single brain. Every one was aware of the strange lethargy that fell upon all of us when the war was over. Abnormal psychology has satisfactory explanations for the extraordinary results that come when an activity into which the whole emotional life of an individual is projected suddenly ceases. Physicians see it often when death ends the long bedside vigil of a devoted wife or mother. That post-war apathy has affected many different fields of human activity, more deeply, perhaps, in this country than in those longer in the war on account of the intensity of our war emotions and the fact that their duration was too short to enable certain stabilizing factors to begin to operate. Wide as were its effects, however, I do not hesitate to say that disabled ex-service men have borne its fullest brunt. The period during which money should have been made available for hospitals, plans for construction prepared, sites secured, and definite hospitalizing policies established was coincident with that of the strongest revulsion of feeling toward war and all that war implies. The post-war irritability, of which every one of us must be aware if we are frank with ourselves, extended apparently even to high officers of the government and, behind the polished plate-glass front of apparent official tranquility, bitter enmities arose and were fought out. During this period of inactivity the "contract" system, by which the care of disabled men has been farmed out to state, county, local, and private hospitals, had its origin and greatest growth.

Were the task of caring for the war's disabled to begin with the present public attitude, the establishment of the "contract" system would never be permitted.

There is nothing to be gained from devoting our attention now to this painful interval. Many of the difficulties that characterized it were unavoidable. Others came from misunderstandings that, while not unavoidable, nevertheless required an unusual amount of understanding, tolerance, and spirit of service to be averted. Some day the historian, the political economist, and the sociologist will discover for us the deep underlying reasons that led the richest nation of the earth to permit a period of almost unbelievable neglect of its disabled defenders to follow the successful termination of its greatest war.

Out of the manifest inadequacy of that three-headed system of administering relief has come the Veterans' Bureau, which represents the kind of mechanism that every one interested in the problem has recommended. All our hopes are centered now in the combination, within that bureau, of the highest type of administrative efficiency and scientific skill. Centralization was accomplished with full realization that a shining mark would be offered to the predatory politicians who are willing to push their enterprises even to the doors of hospitals in which lie disabled veterans, but our faith is pinned to belief in the widespread demand that this national function shall be kept above the level of party politics. The Director of the Veterans' Bureau has been given a trust second only to that reposed in the Chief Executive himself. If he sees in scheming politicians enemies of our soldiers as remorseless as those whom they confronted in France, and prepares and executes his plans for relief with regard solely to the disabled men whose welfare and lives we have entrusted to him, his name will be loved and respected in every American home from which a young soldier went out to battle. If, on the other hand, he permits the exigencies of practical politics to interfere with the faithful performance of his task, he will speedily destroy the opportunity that now exists to make atonement for the mistakes of the past.

A hospital appropriation has at last been made and a program for hospital construction (cut according to the scanty

measure of that appropriation) has been thoughtfully prepared and widely endorsed. The problem itself has become less acute in some of its phases. Definite signs are discernible of a reawakening public interest in the welfare of disabled men.

Problems of To-day

Out of the enormous number of different kinds of conditions that require widely different kinds of provision for their cure or amelioration, have emerged two great classes of disabled ex-service men—the tuberculous and those who suffer from mental disorders. According to the latest report from Washington,[1] there are 28,535 ex-service men cared for in all types of hospitals—government and "contract"—as beneficiaries of the Veterans' Bureau. Of these, 11,175, or 39 per cent, were suffering with tuberculosis and 7,804, or 27 per cent, had neuropsychiatric disorders. In other words, out of every ten disabled men receiving hospital care at the expense of the government, six belong in these two great classes. The more acute medical and surgical disorders have run their courses. Death in hospitals has been the termination for 2,085 men. Recovery has ended the need for hospitalization for many more. It is becoming more and more difficult to connect present disability with war service, especially in those disorders that have a long, slow onset and, even after they are developed, remain under cover for some time because of the hesitancy of the patient or his friends to recognize their existence.

The problems presented by tuberculosis and neuropsychiatric disorders have many points of similarity. Both are long-continued diseases. In both, hospital treatment extends over many months or years and even then constitutes but one phase of a scheme of life management. Both disorders require special types of hospitals for their successful treatment. When you hear the theory advanced that it is more scientific and humane to care for these patients in general hospitals, do not be deluded. It is true that the reception and observation of both tuberculous and mental patients can

[1] September 22, 1921.

be carried out very successfully in special wards or pavilions of general hospitals, but we must remember that the observation period is usually relatively short and the patient's time is much occupied by examinations, tests, and laboratory investigations. It is both unscientific and inhumane to care for tuberculous or mental patients for long periods of time in general hospitals. Their presence at games and entertainments and even in common mess halls is resented by other patients. Their endurance of the long confinement necessary is made much more difficult by the rapid movement of the population in other parts of the hospital. They cannot see others continually coming and going without being reminded of the length of their own illness. Their special interests are certain to be subordinated to those of persons with very acute disorders, who tend to absorb an undue proportion of medical and nursing resources. The only reason for such an arrangement is its economy, but if we are to judge economy in a broad way, with reference to the enormous cost of maintaining uncured patients, there is scant justification for believing that real economy can be thus obtained. Special hospitals for tuberculous and mental patients are required to meet the increase to be expected until the "peak of the load" has been passed, and, more urgently, to replace the extremely unsatisfactory provisions that now exist in many "contract" hospitals.

The only way in which suitable beds can be provided is by building hospitals. No one will ever know the resourcefulness and skill with which the doctors and nurses working in converted schools, hotels, and reformatories have carried on hospital activities. Interior changes—tearing down or building up partitions and installing special apparatus—have made satisfactory emergency hospitals out of some of these institutions (and pitiful makeshifts out of others), but, compared with buildings designed for the treatment of the sick, most of them are very far from being hospitals. The new government hospitals must be near the men they serve. Such a project as that of having a great institution for 7,000 mental patients in the city of Washington ignores entirely the human aspects of the question. You cannot tear these young men from their families in El Paso, Seattle, Duluth, Jacksonville,

or Pittsfield and send them to Washington, to be treated in a vast institution in which their individuality is at once submerged. They have parents, brothers, sisters, or young wives or sweethearts still living who must see them to be convinced that they are receiving the treatment to which they are entitled and to bring to them messages of love and encouragement. Even in England, whose total area is less than one of our smaller states, it has been found necessary to have a number of small hospitals rather than a few large ones in order that men suffering from long-continued illnesses such as tuberculosis or mental disorders may be within reach of their home people.

It is obvious that the treatment of tuberculous and mental patients in hospitals constitutes only a phase and sometimes the least important one of their entire medical care. Many men need never go to hospitals at all if good out-patient relief is at hand. The development of an adequate system of dispensaries will not only provide treatment for many disabled men who would not otherwise secure aid, but will relieve the hospitals of a large number of convalescent patients and those with minor disorders who can actually be cared for better at a dispensary than in a hospital. Especially in the case of functional nervous diseases, hospitals can create or prolong invalidism as well as cure it.

For tuberculous and mental patients, more than for any other class, social service is an indispensable part of treatment. Important and necessary as is the hospital in the management of certain phases of these disorders, the permanence of cure and the reëstablishment of a comfortable, useful, and happy life in the community during periods of remission depend upon community supervision. Fore-treatment and after-treatment can no more be separated from institutional treatment than the preparation of a surgical patient for an operation and his post-operative care can be separated from the operation itself. Here is the great duty of the American Red Cross in its reconstruction activities on behalf of disabled ex-service men. If the files of the various chapters could be laid open, it would be seen that, in thousands of cases, social-service activities averted disaster during the period of governmental neglect and, in a few instances,

brought about complete personal or social recovery without direct governmental aid. No other organization has ever existed which can so effectively bridge the gap between the necessarily formal activities of the government and the informal affairs of the home. If this indispensable partnership is maintained, it is possible to conceive of a large number of tuberculous and mental patients among ex-service men some years from now who will be continuously under the watchful care of the Veterans' Bureau, sometimes in a hospital and more often in the home, where this organization takes on the direct responsibility that the government temporarily lays aside.

There has crept into discussions of soldier relief a note of pessimism as to results which now constantly reappears. Some pessimism is justified by the severity and the chronic character of the conditions now requiring treatment, but there never existed a class of sufferers from tuberculosis and mental disorders that offered such promising material for salvage, if not for complete restoration, as these young ex-service men. It is not necessary for them to recover 100 per cent to resume a very large share of their family, social, and economic responsibilities. Compensation, wisely, skillfully, and humanely awarded, can be made to serve, not as a means of prolonging invalidism and discouraging initiative, but of making good the inroads in earning power created by disease and helping to insure medical or social recovery. It is too late to bring the advantages of early recognition and intensive treatment to many of the men suffering from these disorders who applied during the early part of the three years just closed and found no facilities available. Restitution can never be made to many who suffered through the evils of the "contract" system or the tardiness of the administration of relief, but now—to-day and to-morrow—those inadequately cared for can be reached, the "contract" system can be so employed as to utilize its benefits and avert its harmfulness, dispensary relief and social service can effectively supplement and diminish the shortage of hospital facilities, and the shortcomings of the past can be compensated for by the successes of the future.

The spirit with which the war was conducted has been demobilized, although the disabled in hospitals still constitute a little army in themselves and those who are enlisted for life in the cause of service to the disabled have had their duties increased rather than diminished. I have been about a good deal since the armistice and have visited many hospitals for ex-service men in many different states. Perhaps I may conclude with some rather personal and unrelated observations that bear upon our mental attitude toward disabled men.

Let us not be misled by loose talk about "fakers", "goldbrickers", and "compensation chasers". Of course, there are such men among those who apply for relief. You will find them in colleges, in business, in politics, and even in churches. Those who are attempting to defraud the government should be held responsible for their delinquency in just the same measure as other ex-service men are held accountable for other offenses against the law. Those who err through ignorance should be *educated* into the self-reliant Americanism that characterizes nine-tenths of their comrades. Those who, through weak wills, self-pity, or the demoralizing effects of long-continued and sometimes ill-advised hospital residence, are claimants for benefits to which they are not entitled, should be *treated,* as society is preparing to treat many of its inadequate members who are far less deserving than these. But let us not magnify these problems or permit them to be magnified by those who, in their hearts, are not well-wishers of disabled men. Remember that one swallow does not make a summer. Fraudulent claims are as infrequent as cowardice or self-inflicted wounds were in the army, and unduly fixing attention upon a few unworthy men among discharged soldiers is as unjust and harmful to the others as fixing attention upon those who failed to perform their duties while in military service. We are quick to forget ninety-nine honest men if we fix our attention too intensely upon the one dishonest man. Many a young doctor has thought of abandoning medicine and becoming a truck driver when two of his patients have died in one week, forgetting for the moment those who were hardy enough to survive. Remember, too, that there is one type of disease in which the essence of the disorder itself

is self-deception. To the psychoneurotic, symptoms of weakness and disability are as real as are delusions of wealth to the man who suffers from general paresis. The way to change his mind about it is to cure his mind. When talking about malingering, let that person among us who never escaped a difficult situation or an inconvenient engagement through a headache or the aggravation of a cold cast the first stone. Let us be severe with the offender, but not, in so doing, unfair to the thousands who do not offend.

Let us not be misled by the constantly reappearing statement about those six thousand empty beds that make further provision for tuberculous and mental patients unnecessary. Most of these beds are needed to constitute the reserve without which no hospital with an active service can operate. Others are empty because they are for the exclusive use of different types of patients from those for whom accommodations are now so urgently needed. An empty bed in a first-class hotel does not do much toward relieving the pressure created by ten lodgers occupying a three-room tenement apartment. There are plenty of empty farmhouses on the abandoned farms of Vermont and New Hampshire, but they do not relieve the housing shortage in the Eastern cities. A bed is not a rectangular, metallic structure upon which to lay a sick person. It is a *fraction of a hospital* surrounded by a tenth of a nurse, a fortieth of a neuropsychiatrist, and a five-hundredth of a medical director. It must be in a hospital capable of treating the type of disease from which the patient suffers. There is to-day a shortage of suitable beds for the care of tuberculous and mental patients. It is true that practically all such patients who apply for treatment are sheltered, with the exception of some mental cases, but many of them are in institutions utterly incapable of giving treatment such as they require.

Only a few of the problems of disabled ex-service men have been outlined in the broadest possible way. I have tried to show that hospitals—real hospitals, not phantom hospitals—are needed, that dispensaries and social service are quite as essential as hospitals, that many of the difficulties in the way of adequate relief which seem so formidable have been unduly magnified, and that, in spite of our talk about

"terminal conditions", "chronic disorders", and "incurables", great opportunities for curing sick ex-service men still remain. All the facilities and activities that I have spoken of might be brought to a high state of perfection and nevertheless result in failure or relatively small success if one other factor is lacking—a spirit of service similar to that which inspired our work for the disabled three years ago. It is too much to expect the patriotic fervor that then animated all our efforts to come again except in a grave national crisis. Mobilization of all our resources in men, women, and material cannot now be invoked to aid this handful of disabled men. A breath of the spirit of 1918 can, however, if we relentlessly hold before our eyes the contrast between our attitude then and now. Let us silence counsels of false economy, hopelessness, and suspicion, and put the performance of this sacred duty back upon the high level of patriotism from which it should never have been dragged. Those who groan about the burden of caring for disabled men, whether in administrative offices, hospitals, or the home, are unworthy to bear that burden. In twenty years a new generation will envy as greatly those who now have the duty and privilege of binding up the nation's wounds as they will those who defended her during the war. This job must be done as many a bigger one was done in the war—uncomplainingly, willingly, cheerfully, and with a confidence in its successful accomplishment that knows no such words as "compromise" and "failure".

THE STATUS OF "CLINICAL" PSYCHOLOGY

F. L. WELLS, PH.D.
Chief of Psychological Laboratory, Boston Psychopathic Hospital

THE problems of civilized human adjustment have long since divided themselves up among certain systems. Medicine has looked after man's body. Law has looked after his social relationships. Religion has assumed the care of his otherworldly relationships. The present discussion concerns psychology as a factor in these various disciplines, with special reference to medicine.

The lack of coördination between medicine and psychology, in their application to the guidance of conduct, arises from the development of types of work, of a psychological nature, that have an appropriate place in the management of certain clinical and social groups of cases. This work is little covered in medical training, or, save exceptionally, by medical men. It is being covered more and less well by persons more and less competent in psychology or its techniques. With the ambition to be of service goes responsibility for adequate performance of that service. There is a growing sentiment that if psychology is to take its proper share in the guidance of human adaptations, there must be a more responsible organization of its work for this purpose.

Under the auspices of the National Research Council, there was held at Washington, in the spring of 1921, a conference of representatives of psychiatry and psychology, to discuss the difficulties of the situation and to promote a better understanding of the respective points of view.[1] The purpose of this paper is to review some of the nuclear remarks made on this occasion, with particular reference to the medical point

[1] The following associations took part in the conference: American Association for the Study of the Feebleminded; American Medico-Psychological Association; American Neurological Association; American Psychological Association; American Psychological Association, Clinical Section; American Psychopathological Association; National Committee for Mental Hygiene; National Research Council; National Research Council, Division of Medical Sciences; New York State Association of Consulting Psychologists; Southern Society for Psychology.

of view and its indications for action on the part of psychological organizations.

It is easy to agree that medicine and psychology should coöperate for the public good, etc. The essential issue is raised in asking whether such coöperation is to be secured through a new professional class, the psychologists, or through an infiltration of psychology into the medical curriculum. Forecast is made of a person "with biological, educational, social, psychological, and medical background; he need not have the various types of training in obstetrics, surgery, and the other varied fields of the conventional medical course."[1] Such a person should work as a highly qualified expert in the field of mental adjustments.

To a program like this medicine would accede provided the training were given in a medical school, with enough of general medicine to justify the medical degree, and with the assumption of medical responsibilities. In thinking of background, one should perhaps guard against overloading the informational side of such a program. Most of the informational detail to be insisted on is of a medical character. There is certain information that must be available before any maladjustment case is handled with ordinary safety, and this information is not to be had save through medical training. As medicine sees it, the specialist postulated will have to be a physician.

There is, however, a group of "clinical" psychologists large enough and coherent enough for the development of a definite *esprit de corps*. Certain conditions affecting a professional class of this kind should not be lost sight of. It belongs with the law and with medicine in dealing with human adjustments, as against engineering, for example, which deals with material things. The practitioners of law and medicine are in great part supported by individuals who seek professional help—from the doctor when they are feeling sick, from the lawyer when they are feeling wronged. The value of a profession for private practice upon human beings depends essentially on what it can do to get people out of trouble. If psychology is to develop further as an accom-

[1] Harry L. Hollingworth, PH.D.

plishment of private practice in this sense, it must be able to take care of a certain class of individual troubles better than the lawyer or the physician can take care of them. Before predicating the development of a professional class of consulting psychologists, one must consider carefully how great is the class of troubles that psychology is distinctively qualified to meet. They are not unallied to the type of difficulties that now go to the religious confessor or to systems of healing that have a quasi-religious basis. There are grave difficulties in the way of meeting this type of troubles with the setting of scientific psychology that is now available. This is not out of harmony with the fact that individuals of good personality and exceptional insight have been able to make of themselves a *Vaterersatz* in the psychoanalytic sense, to guide less stable personalities among life's pitfalls, and earn material reward therefor, all in the name of scientific psychology. Such things are done in the name of medicine or law also, not to mention systems of far less standing. It is on these individual grounds that the few conspicuous successes in private work that psychology records seem best understood. They are not protagonists of a professional class of the same standing that they, as individuals, represent. A professional class of a less pretentious order, the expert in mental measurement, or psychometrist, is already a part of the educational, and to some extent the psychiatric, system. Medical education here seems of rather less relevance than in the case of the dental practitioner. Few psychologists, however, would see in this development a solution of the problem, or consider that it adequately represented the contribution of psychology to medical or educational science.

On the medical side, an approach to the adjustment already suggested is made through a three-year graduate medical course, at the end of which "one might be more or less authoritatively designated as a psychiatrist or neuropsychiatrist".[1] With such training one should come as close as is practicable to the ideal of the "psychobiologist". In considering the substance of psychology's contribution to such a course, it should not be forgotten that practical, if not psy-

[1] Hugh T. Patrick, M.D.

chologically systematic, study of human behavior pervades the whole atmosphere of medical training to an extent approached in no other discipline save perhaps the law.

The program suggested in the above paragraph is clarified by a proposal for "the development of medical education along the lines of extending the responsibilities and correspondingly the educational and practical equipment of the physician. . . . The physiologist would have been compelled to undertake certain practical work for mankind had not medicine adopted physiology . . . as a basic science. Now if the medical profession is prepared to take over psychology . . . either as an independent science or as an extension of physiology, it seems that we have one possible solution of our present practical difficulty."[1]

In view of such considerations, it is not surprising to find argument from the side of psychology for the introduction of psychobiology into medical education as a basic science. It is said of psychology and psychiatry that "one is very obviously a branch of science, the other a particular application of scientific knowledge."[2] The term psychology is like chemistry in denoting both pure and applied science, but psychology has in psychiatry a term whose etymology denotes application. Actually, also, "clinical" psychology is non-medical psychiatry.[3] So soon as psychology, the science, is applied to human difficulties, it falls within the definition of psychiatry. The present teaching of psychiatry involves not a little teaching of psychology, whose fragmentary character is somewhat offset by its concreteness. The suggestion is offered that a saving of time when it is of particular value would be effected if the student had a carefully designed course in psychology early in the curriculum, or pre-medically.

The nearest alternative to the gradual incorporation of the medical phases of psychology into medical education is for "the psychologist to continue his present efforts to establish definite standards for psychological work, to lay down high

[1] Robert M. Yerkes, PH.D.

[2] Robert M. Yerkes, PH.D.

[3] A psychologist has recently been appointed psychiatrist to the Bureau of Public Welfare in one of the Southern states.

definitions of what it is to be a psychologist, and to get these on record. . . . On the other hand, psychiatry must continue to educate the medical profession to look upon itself as a distinct specialty dealing with mental disease in a strict sense."[1]

The first of these proposals may and should be carried out irrespective of other developments. It happens that the medical phase of psychology where standards can be most objectively formulated is in the field of psychometrics. It should be a matter for official concern that the popular or medical conception of "psychologist" does not come to represent something confined to the psychometric level. While "high definitions" must be less objective, these considerations make them probably as urgent. Any standards now practicable should be formulated with the expectation of making them progressively more exacting. Ultimately they should embody medical requirements.

The physician's disposition to concede the second point does not appear. It is contended that "the whole progress of clinical medicine is toward dealing with minor and relatively insignificant departures from health, where there is opportunity for prevention and early treatment."[2] Contemplation of the number and type of problems referred to psychiatry in out-patient services, or in contact with school systems, offers little prospect that this extension of medical activities will be limited by developments within psychology.

The *imponderabilia* of medical discipline receive from the conference not more than their due weight. No class that does not pass through a comparable discipline should expect to enter into the privileged relationship of the physician toward his patient or the attorney toward his client. The old saying that one should always tell the whole truth to one's doctor, one's lawyer, and oneself, expresses the almost equal privileges of the two relationships. "The doctor has developed, during his medical course and hospital interneship and practice, a protective and responsible relationship towards sick persons that no other profession has. . . . In every civilized country women and children are entrusted in the

[1] Harry L. Hollingworth, PH.D.

[2] Thomas W. Salmon, M.D.

most confidential relations to physicians with hardly any casualties."[1] In the varied and scattered training, sometimes one of sophistication rather than of experience, that now connotes the psychologist, there is nothing comparable to this medical training.

There is a rather strong feeling among medical men, not unshared in psychology, that the discipline of medical training is a proper prerequisite to certain types of psychological research. These are exemplified as "the mental aspects of the sex life in children, people who are feebleminded, diseased, prevented from exercising a normal choice as to the extent of the investigation or the method."[2] It is largely felt that matters thus touching on intimate and emotionally charged topics should be studied by medical men or under medical direction. Interest in such studies is by no means a criterion of qualification for them—it may be quite the reverse. Their significance as a sexual *Partialtrieb,* the rationalization for them derivable from psychoanalysis, with the easy abuse of laboratory license, make it important in medical eyes that such avenues of research should be carefully guarded. That the discipline of the medical course does contribute to a more objective attitude toward such topics is hardly to be questioned. Stress is also laid on the responsible nature of the physician's relationship, now far from established in the case of the psychologist.

It is thought that these points are often passed over too casually. "The training of the medical man is not merely the question of giving him a certain amount of information . . . he is brought into very special and somewhat privileged relation with sick people in regard to very vital issues. . . . This training enables the physician to put aside a great number of conventional prejudices and personal feelings."[3]

It is argued, and again with reason, that "medical training does not include the whole range of human behavior, nor does it concern itself with all problems of adaptation. There appear to be problems that have a wider significance than those which the medical training so far offered has enabled

1 Thomas W. Salmon, M.D.
2 Thomas W. Salmon, M.D.
3 C. Macfie Campbell, M.D.

one to handle well."[1] This returns to the vital part of the issue. Granted that there is such a lack in medical training, is it to be supplied through *psychology* or through *psychologists?* Is the question that of a professional class seeking to establish a standing as such, or is the contention for the place of a certain discipline in that system of training which is historically responsible for the organism's well-being?

Medicine should not be expected to look with favor upon the management of an ailment independently of medical authority. It is said that some people will go to a psychologist before they will to a physician, nor can the psychologist, without sacrifice of the patient's interest, at once send them to a physician. The physician replies that such cases are insignificant in number. It must not be lost sight of that very similar considerations would apply to persons who have first recourse to various systems of faith healing. The point is made that one does not fulfill one's duty to the patient without the best practicable control of objective factors with which the physician alone is trained to deal. Recognition of this is not lacking in psychological quarters. "There would be no hesitation on the part of all psychologists to feel that medical examination was desirable and essential, even if the findings were negative. . . . The question of sequence will arise. Which examination is to precede the other?"[2]

To some extent this question answers itself in terms of the type of examination to which the individual first comes. As to synthesis, undoubtedly there are cases in which psychology provides a better synthesis than does medicine in its ordinary sense. Also, there are psychologists who can synthesize such cases better than the average physician. The best equipment for synthesis now available seems to be a genius for certain aspects of psychology plus a medical education.

A physician states the ethics of the situation to the effect that "in the community where there is a well-trained body of medical men who have spent years in studying these disorders, it would be the natural thing, the desirable thing, for the psychologist to refer these cases to these individuals. In a community where such people are not available, then it might

1 David Mitchell, PH.D.
2 Francis N. Maxfield, PH.D.

be proper for the psychologist to deal with the cases in the light of his special training. The psychiatrist living in other communities would not resent this. One would like to have in every community the possibility of the individual getting help of a rather advanced nature."[1]

Attention is directed to complications that may arise in the cross-reference between psychologist and physician. "Suppose the patient originally goes to the psychologist, who refers him to a physician, who finds him physically all right. . . . There is no assurance that the patient will remain that sort of patient. The question of diagnosis cannot be disposed of once and for all. . . . If the psychologist is not familiar with psychoses, he is not in a position to decide either at the beginning or at any other stage when the individual needs medical help."[2]

It will probably be approved by all physicians, and by many psychologists, "that the terms 'clinic' and especially 'clinical' be eliminated from the psychologist's technical vocabulary. The introduction of these terms has, to be sure, been innocent enough, but it now proves to have been unfortunate. Clinical psychology as it exists to-day is something entirely different."[3] The most forcible objection is the implication of a medical setting where none exists. The clinical psychologist also finds a large part of his work in educational rather than in pathological fields. As indicative of something the psychologist does not do, and not indicative of what he does, there is no term whose tabu at the hands of the psychologist is more advisable. A prominent medical school lists a course in "clinical physiology". In such a setting, it is not impossible for clinical psychology, as that portion of clinical practice concerned with the mental processes of the patient, to find a more descriptive application.

However extensive its boundaries, it is surely clear that the explored territory of psychology and the degree of organization within it do not constitute it a discipline coördinate to medicine or law or religion. Psychology is one of those sciences that have particularly to do with human health

1 C. Macfie Campbell, M.D.

2 Hugh T. Patrick, M.D.

3 Communication from Robert S. Woodworth, Ph.D.

through human adjustment. The other sciences of this character have developed naturally as medical sciences. Distinguished names attest that the early days of psychology did not lack points of contact with medicine. Overlapping has been more recent.

Neither anatomy nor pathology nor physiology nor psychology is so constituted as to carry the whole weight of a human-adjustment problem. Psychology is the latest of these to bring forward knowledge of particular value in such problems. As such, it has a similar, but not greater, place as an autonomous profession than belongs to other medical sciences or to different branches of the law. All of psychology, indeed, is not a medical science, any more than is all of chemistry, from which medicine takes over its biological aspect. The "mental age" of psychology is that of chemistry fifty years ago, yet to take over psychology might be a larger order than could profitably be disposed of. If medicine does attempt to take over psychology, it is right to ask the taking over of not less than is relevant to medical problems in the broad sense in which medicine now conceives them. In one field of psychology—namely, psychoanalysis—principles and methods were both developed by physicians.[1] To this should be added the simpler, but more objective field of psychometrics, while granting that much routine work in this field requires no more psychological than medical background. Psychometrics should be covered up to the point where the cases in hand cease to be medical problems, wherever this line be drawn. The general course in psychology should be based on genetic study of the personality, giving more attention to affective and instinctive life than does psychometrics, but having a more objective foundation than psychoanalysis. If medicine is to dominate the field of human-adjustment problems, it should incorporate as much of psychology, as of other science, as is relevant thereto. This seems to be the best solution both for medicine and for psychology. Should one expect the standing of non-medical psychologists to be unfavorably affected by such a development? While medical education will un-

[1] It cannot be too clearly realized that psychoanalysis is not a medical application of principles discovered by others, but grows out of principles and methods developed for strictly medical purposes by men with that type of training.

doubtedly become a more and more frequent and advantageous part of the consulting psychologist's equipment, this need not prejudice the standing of the consulting psychologist with competence already established on grounds of research, teaching, and personality. Persons being trained to-day in psychology have an advantage over their fellows of twenty years ago not incomparable with the advantage that medical education offers to the psychologists of the future. How seriously has this affected the standing of those who made this better training possible?

The psychology of to-day is a species of myriapod with feet in the camps not only of medicine, but of religion, law, education, sociology, and industry. In these relationships it occupies a distinctive position and one with unusual possibilities. As Peter the Great labored in foreign shipyards for the advancement of his undeveloped country, psychology should not hesitate to incorporate itself with better organized disciplines, in which its own progress is the sole limit to its influence, and some of which it may in time come to dominate. Law and education have perhaps not fewer natural affiliations with psychology than has medicine, but these disciplines are less markedly under scientific influence, and there is in them no hierarchy of sciences capable of assimilating the subject matter of psychology.

It is hardly to be claimed that one can acquire sound training in medicine and psychology within the space of four years. A graduate course in psychiatry, such as that before mentioned, would have to carry the greater part of such psychological training as was given. This would be that part of psychology which could be made a graduate medical subject, assuming certain fundamentals pre-medically and in the medical course.

The American Psychological Association recently conducted an inquiry as to what psychological subjects were considered of greatest importance from the standpoint of faulty mental adjustments. A composite of ratings by 81 persons professionally concerned with this class of work rated various course titles as follows, a maximum score for practical purposes being 486:

Mental measurement (first year)	483	Systematic psychology	228
Exceptional children	482	Industrial psychology (first year)	223
Techniques applied psychology	463	Social service (methods)	222
Mental diseases	432	Practice of psychology	198
Mental measurement (second year)	427	Anthropology	196
Educational psychology (first year)	390	Clinical physiology	196
Mental hygiene	382	Class experiments	188
Juvenile delinquency	371	General pathology	178
Physiological psychology	368	Industrial hygiene	168
Neurology: diseases of nervous system	363	Animal psychology	162
Genetic (dynamic) psychology	353	Zoology	148
Genetics (heredity)	344	Education, seminar	147
Child hygiene	332	Personnel administration	145
Psychology of learning	329	Industrial psychology (second year)	133
Sociology, pathological	315	History of psychology	127
Developmental psychology	313	Educational systems	120
Statistics, advanced	307	Embryology	112
Social psychology	300	Psychological ethics	106
Higher mental processes	300	Economics	92
Physiology	297	Business administration (first year)	86
Speech defects	288	Physiological chemistry	77
Vocational psychology	286	Advertising and selling	65
Educational psychology (second year)	285	Bacteriology	65
Biology	277	Business administration (second year)	50
Sociology, general	257	Business ethics	23
Biometric methods	229	Epistemology	3

Subjects of medical bearing rank somewhat conspicuously in this classification. A graduate course in neuropsychiatry might make out its curriculum from the ten subjects heading the above list. The topics that psychologists regard as most important are pretty much those that medicine would undertake to provide. Some of them, indeed, depend on medical resources and cannot be had without medical coöperation.

The main conclusions that seem to emerge are that psychometrics is the task of technical experts who often are not and seldom need to be psychologists in the broad sense that ought to attach to the term. It is doubtful if the problems of clinical or pathological psychology are such as to support an important professional group independently of medical foundation. Medical discipline gives the best background, and an all but requisite type of background, for inquiries involving the major affective life of individuals. There is no funda-

mental conflict between psychology and medicine; it arises among physicians, on the one hand, and psychologists who are masters of certain medical techniques and occupied with certain medical problems that medicine has not assimilated. Medicine should assume greater responsibility for them, when the conflict will disappear. Meanwhile the administrative duty of psychology is to develop progressively higher standards in training and accomplishment and, within those limits where reasonably accurate judgment is possible, means of attesting those who meet these standards. That this can and should be done on the psychometric level seems clear. On the level of the independent consultant, one must distinguish carefully between measures that further the services of psychology to society and those that seem primarily for the interest of a professional group. The latter policy would certainly be without value, and might be disastrous, to the standing of the profession as a whole.

THE CARE OF NEUROPSYCHIATRIC DISABILITIES AMONG EX-SERVICE MEN*

DOUGLAS A. THOM, M.D.
H. DOUGLAS SINGER, M.D.
Advisory Consultants, United States Public Health Service

THE great majority of disabilities falling under the head of neuropsychiatry require special consideration, for the reason that they involve the behavior of the patient and, thus, his relations with society. They are not simple problems in mechanics, comparable to those brought about by the loss of, or defect in, some organ or portion of the body. They concern the activity of the man as a whole, his understanding of the facts of the world, his feelings, and his attitude toward himself and others. In many instances the disorder itself prevents the patient from making a safe decision as to his course of action, and this selection must often be made for him, sometimes even against his will. Such patients cannot be held responsible for their acts, and what is often spoken of as discipline must be here a matter of treatment for disease, to be prescribed only by a physician trained and experienced in mental disorders.

The disturbance in behavior may or may not be combined with, or in some instances be due to, disease or defect in the organs of the body. Hence, in planning for treatment and rehabilitation, it is necessary to provide facilities for every form of investigation and therapy known to medicine, as well as those specially designed for the treatment of nervous and mental upsets. It should also be noted that even where a disability seems to be more or less adequately explained by the presence of a bodily disease or deformity, the disturbance in function may be modified, enhanced, or perpetuated by a disorder of the mental state. It is, therefore, important that neuropsychiatric advice be available to hospitals and relief stations devoted to the treatment of general or special medical

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and surgical diseases and defects. Real bodily ailments, whether serious or not, often serve as a convenient peg on which to hang a whole train of functional disabilities. To treat the former and thus emphasize, and perhaps exaggerate, their importance may do much to retard or even prevent the real recovery of the patient to the full extent of which he is capable.

In the majority of neuropsychiatric cases, there is no definite bodily disease to be combated. The difficulties are those of making an adjustment to the circumstances in which the patient finds himself. These difficulties are in part inherent in the circumstances themselves, but are more largely the result of the personality of the patient. The personality is dependent partly upon inheritance and partly upon training, experience, and alterations in the body due to disease or accident to which the patient has been subjected during life. It is possible to modify in various ways the circumstances to be faced, and the personality can also be developed by fresh training. Thus we can change the work, home, or play surroundings, and we can educate the patient to different habits. It is obvious, however, that such treatment must be individual, and hence requires trained personnel and varied equipment.

For purposes of description, neuropsychiatric cases may be divided into four groups, which differ from one another in the requirements for treatment. These are:

1. Injury or disease of nerve tissue.
2. The psychoneuroses (or neuroses).
3. The psychoses (or insanities).
4. Certain constitutional nervous deficiencies.

1. Injury or Disease of Nerve Tissue

Group 1 is comparatively small in size and relatively simple in its requirements. It includes such cases as gunshot and other accidental injuries to nerves and the damage produced by diseases of the nervous system, such as meningitis, "strokes" of paralysis, etc. Uncomplicated disabilities of this kind can be adequately treated in general hospitals or relief stations.

It should be especially emphasized, however, that psycho-

neurotic additions are not at all infrequent and are very likely to be overlooked. All such cases should, therefore, be studied with this possibility in mind.

2. The Psychoneuroses

In point of actual numbers this group is by far the largest, but for hospitalization it should be extremely small. It includes the great majority of those conditions which were loosely and erroneously described as "shell shock" during the war—the "nervous breakdowns", hysteria, neurasthenia, anxiety neurosis, psychasthenia, and the so-called "functional diseases" of the heart, stomach, and other organs.

In essence, the neurosis is a "way out" of some intolerable conflict or difficulty. The feelings of stress, apprehension, and worry that belong to the conflict are interpreted by the patient as evidences of disease or injury, the origin of which is referred back to some accident or illness—gassing, influenza, overwork, etc.—of the more or less recent past. The suffering is genuine and none the less real because the symptoms are ascribed to disease or injury. The case of a soldier seen at one of the hospitals will illustrate. This man served as a commissioned officer and was slightly gassed. His pre-war social status and occupation were those of a railroad brakeman and to these he was obliged to return upon discharge. He did not openly admit, even to himself, that this loss in authority and social dignity and the return to a monotonous routine were unbearable and distasteful. He could not afford, or could not see his way to manage, to take vocational training under the conditions of Section 3.[1] He fretted and worried, was unhappy and dissatisfied, and sought an explanation for these feelings other than the facts which he was unwilling to accept. The "gassing" experience offered a way out. He experienced upsets in his breathing as part of his emotional state, but wondered if they were not due to the damage done by the gas. The more he watched them, the worse these feelings became, and soon they were so severe that he had to give up work and thus was relieved of his distasteful and humble position.

[1] Section 3 of the Vocational Rehabilitation Act.

The treatment of such cases must consist of discovering the conflict or difficulty, convincing the patient of the real facts, and then helping him to find some more satisfactory method of dealing with it which is within his capacity. Obviously this must be individual and cannot be applied to patients in groups or in a routine way. It requires skill and tact, often with the devotion of considerable time upon the part of the physician to this one patient. It is, therefore, not surprising to find that the field officer who has many patients to see and no special clinic to which to refer such cases will immediately recommend hospitalization.

To place such a patient in a hospital is to confirm his belief in the existence of serious disease or damage. Furthermore, it very effectually brings a cessation of the responsibilities and needs for adjustment that brought about the disorder. It is often extremely difficult to discharge such patients; it is a much simpler problem to keep them out of a hospital. No man can be taught to carry a heavy burden by being relieved of the necessity for carrying anything at all. It is true that in some instances the burden may be more than the shoulders can bear. The shoulders must then be trained to bring them to their full strength. If it be found that the load is still too great, steps may be taken to diminish it, but it must not be removed entirely unless we desire to retire the individual from active participation in life.

We were somewhat surprised, during our visits to the hospitals, to observe many patients with marked hysterical symptoms. As a rule, these rapidly disappear under appropriate treatment, and this observation served to confirm our belief that hospitalization should be avoided. In fact we are very strongly of the opinion that *special hospitals for the treatment of psychoneuroses will eventually be found unnecessary, provided adequately staffed out-patient clinics are established.* Short residence in a hospital may be necessary in a small proportion of cases, but these could be cared for in the diagnostic hospitals of the district. One of us (Dr. Thom) has recently had under treatment in an out-patient clinic 680 psychoneuroses in ex-service men. Of this number only a little over 4 per cent needed even a short time of hospital residence.

The above considerations also emphasize the importance of seeing that psychoneurotic patients, if they are to be hospitalized at all, are not sent to an improvised hospital in which facilities for treatment are not at once available. So much depends upon the atmosphere and the absence of incentives to loafing that hospitalization under such conditions will inevitably do more harm than good.

3. The Psychoses

While this group is actually smaller in numbers than group 2, its need for hospitalization is many times greater. The psychoses differ from neuroses in that there is a definite loss of touch with reality upon the part of the patient. He does not merely regard himself as sick and incapacitated, but his conception of the facts of the world, of himself, or of both are definitely distorted from the reality. As a direct consequence, the behavior is not appropriate to the actual facts of the surroundings, and there is likelihood of the performance of acts that may harm the patient or others. For this reason the patient must usually be removed from ordinary social life, and it is often necessary to restrain his liberty.

The great majority of psychoses must be treated, often for long periods, in a hospital. The requirements to be met are fairly well established and need not be discussed in detail here. In fairness to the medical officers of the hospitals now in operation it should, however, be pointed out that special arrangement and equipment of wards for the care of acute mental upsets are very important. The improvised facilities provided by the hasty modification of buildings constructed for an entirely different purpose will nearly always be deficient in some important particulars. It cannot be too strongly urged that every effort be made to erect hospitals built for the purpose, at the earliest possible moment, and thus do away with the necessity which now exists for doing the best that can be devised at short notice with existing structures. The quieter and less disturbed mental cases can be treated in buildings of very simple type; but since there is always the possibility of the recrudescence of acute disturb-

ance, there is always the likelihood of the need for the provisions above mentioned.

In many psychoses there is some underlying disease of the nervous system; whereas in others little has as yet been definitely established. Many seem to arise upon the basis of conflicts and difficulties similar to those indicated for the neuroses, but with, perhaps, an added factor of poor construction either from the start—i. e., from birth—or as the result of damage from disease or injury during life.

The information obtainable from the patient as to the history of his life and the factors that have led to the mental breakdown is often incomplete, unreliable, or even completely lacking. To do the patient justice, it is, therefore, essential to supplement this information by outside investigation. For this purpose a well-organized social service is necessary. At present this is being performed by the American Red Cross, but there are so many ways in which social service is needed that there is ample justification for the development of a special service with thorough training in neuropsychiatric work. Such a social service would act not only to collect information, but also to assist in the rehabilitation of the patient during the difficult period following his release from the hospital.

4. Constitutional Nervous Deficiencies

As the title implies, this group includes cases that were not normal when they entered the army. Yet, in many of them, army service is responsible for the present degree of disability. Prior to enlistment, the man had found a niche into which he fitted. Service has broken this adjustment, has perhaps aroused ambitions and dreams incapable of realization, and has created cravings for companionship and other things that were previously unknown. The principal problem is, therefore, one of replacement in a suitable environment, very rarely one of hospitalization.

Three different types may be mentioned that present somewhat varying requirements. They are (a) the feebleminded, (b) the psychopathic personality (constitutional inferiority), and (c) the epileptic.

a. *The feebleminded.*—The feebleminded man who was ac-

cepted in the service is in practically all cases among the higher grades of defective. He is capable of placement in some activity, though the effort to carry this out may have to be repeated many times before a finally successful adjustment is secured. In attempting this placement and vocational training, it is essential that the capabilities of the man be very carefully studied. An unwise selection may result not only in the discouragement of the patient, but also in greater disability than was present at first. To take up responsibilities too heavy for accomplishment lays a very excellent foundation for the development of a psychoneurosis in the feeble-minded just as it does in those of higher intelligence. Selection of vocation and environment should be made by an expert, with all the advice he can get from the physician who has really studied the patient. It cannot be successfully made in a fifteen- or thirty-minute interview by some one who knows little more than that there is a demand to fill certain jobs. We believe very strongly that these efforts should be carried out with the advice and supervision of the out-patient clinic that is responsible for the treatment of the patient.

b. *The psychopathic personality.*—The psychopathic personalities present some of the most difficult problems of all. Such persons may show comparatively low intelligence, but they may also grade even above the average upon test. The essence of the defect lies in the personality. There appears to be inability to use the intelligence to guide the behavior. The man may seem to have the knowledge that should enable him to select what to do with fair judgment, and yet he does not use it. He may perform all sorts of ill-considered acts to gratify the appetites of the moment without consideration of the consequences, even though he knows them when questioned. He may commit delinquencies of all degrees of seriousness, from vagabondage, lying, stealing, and forging to murder. It is often alleged that he is insane and he may find his way to a hospital, where he is a constant source of trouble, frequently escapes, and is always a menace. Often such persons are plausible and superficially shrewd, but they seem to be incapable of steady application and soon tire of any task. In numbers the group is fortunately small, but the potentialities

for evil are large. No state has yet succeeded in dealing with this group satisfactorily.

c. *The epileptic.*—The epileptic in very many instances can get along in the community, especially where compensation and supervision through an out-patient clinic are possible. Such a person is severely handicapped from an industrial point of view, more so than many with more obvious defects. In a certain proportion of cases, when the fits are frequent or the patient has difficulty in adjustment due to personality, segregation from ordinary society is advisable. The character of the institution to which he is sent should be that of a model community with its own industries, amusements, etc., rather than a hospital. In the case of epilepsy, probably more than in any other group, it is important that the patient be not sent to an incomplete and improvised institution. Most epileptics are impulsive and inclined to grumble, but these traits are rapidly increased by idleness and lack of attention. In constructing buildings to house epileptics, the possible dangers resulting from the falling of patients should be kept in mind. We believe that such an institution should be planned and built, but this must be secondary to the more urgent need for hospitals for psychoses. Epileptics with psychoses will go to these hospitals.

The above considerations as to the nature and needs for treatment of neuropsychiatric cases lead us to make some general suggestions with regard to the organization of the work. Since the neuropsychiatric work must be coördinated with the other medical work, the outline here given does not deal only with the former. This outline is purposely very general and open to wide variation in regard to details; but it contains some points that we consider essential to the efficient operation of the neuropsychiatric units.

Plan for the Organization of the Treatment of Disabled Ex-service Men

1. The work in each district is subdivided into administrative and professional branches. (See chart, page 32.)

The *administrative branch* makes the first contact with the patient, either directly or through some public or private

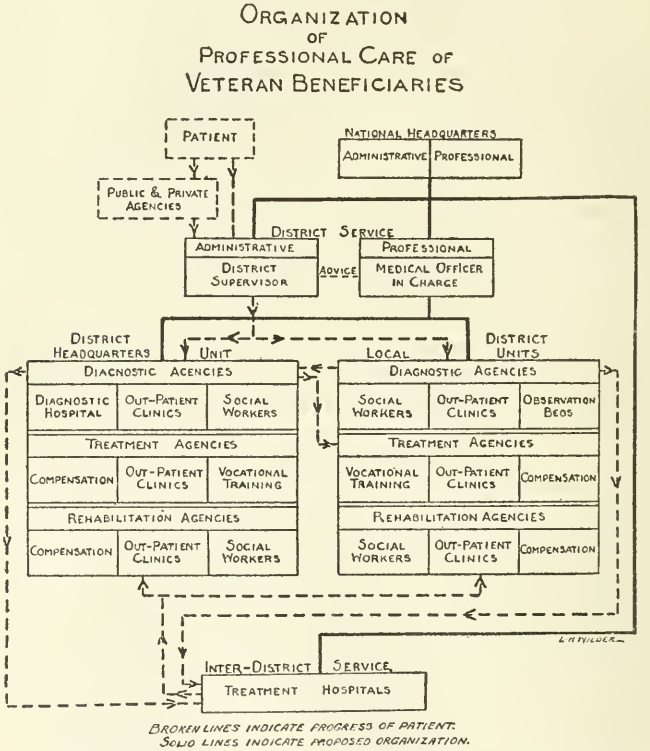
agency. The patient is then immediately referred to the most convenient out-patient clinic. This branch also determines the compensability and, under the advice of the professional branch, settles the rate of compensation, issues all necessary orders, and makes all arrangements for transfers from or to headquarters unit, local unit, or treatment hospital.

The *professional branch* is provided with a series of medical units located at convenient points throughout the district. One of these, the headquarters unit, stationed at the headquarters of the district, is subdivided into special and general medical subjects, is provided with sufficient hospital accommodation for the detailed study and short-term treatment of such cases as may need it (here called the diagnostic hospital), and has access to specialists in all fields, who need not always be on full time. The local units will be of suitable size for the communities they serve, will be provided with a few beds for study or temporary hospitalization, probably by contract with a local hospital, and will hold clinics in the specialties only as frequently as may be necessary. Patients who need more detailed and special study than can be given at the local unit can be transferred to the diagnostic hospital of the headquarters unit. Whole-time neuropsychiatric consultants will not be needed at the local units unless these units be large. They can sometimes be appointed from the membership of local physicians, or the clinic may be served by whole-time specialists traveling from the headquarters unit.

It will be noted on the chart that compensation is given as a means of treatment or rehabilitation. This view of the matter is considered essential. Vocational training has also been placed among the treatment agencies. It should be possible to prescribe training for portions of a day as well as for a full day so that it may be used in the treatment of patients who are unfit for a full day's work. The term rehabilitation is here used to apply only to the replacement of the patient in full citizenship or such degree of self-support as may be possible when all means of treatment have been exhausted.

2. Hospitals for prolonged treatment, especially for the psychoses and tuberculosis, will probably serve several districts. On the chart they are indicated as treatment hospitals. Pa-

tients will be sent to these hospitals upon the advice of the medical officers of the out-patient clinics, either headquarters or local, and will always be discharged back to the care of the out-patient clinic, which will give any further treatment that may be indicated and will supervise the rehabilitation.



It is essential that arrangements be made to transfer copies of the medical records of the patient whenever the patient is transferred from clinic to clinic or from clinic to hospital or vice versa; otherwise many unnecessary examinations must be made which are annoying to the patient and cause much waste of time and effort.

3. From the description and chart, it will be appreciated that, under this plan, *the out-patient clinic is the center of the service.* This, we believe, is the only logical solution; it is especially important for the neuropsychiatric work. Many cases are now being hospitalized to their own detriment because of the absence of facilities for giving treatment without it.

4. Whatever plan of organization be adopted, we would especially emphasize the importance of establishing the very closest coördination between the agencies that have to do with treatment, compensation, and vocational training.

Trained Neuropsychiatric Personnel

In our opinion the greatest need of the service at the present moment is for trained personnel. It is an unfortunate fact that neuropsychiatric medical officers, nurses, social workers, etc., exist only in limited numbers, in no way commensurate with the demands. The plan of work must, therefore, be made with the greatest economy in mind. All competition between various agencies of the government should be eliminated, and the fullest possible use should be made of civilian experts on a part-time basis.

The plan of organization suggested above makes this possible, as the largest field is at the headquarters unit of the district and is located in the largest center of population. In selecting the site for out-patient clinics and diagnostic hospitals, convenience to consultants should be considered. In selecting assistants, it should be noted that the character of the work most needed in the out-patient clinic is different from that in the treatment hospital. The latter resembles more, in the class of work, the state hospital. The former will have a large number of psychoneuroses and also recovered psychoses for rehabilitation.

To supplement the available supply and to prepare for the increased demand that will come with the opening of new hospitals and out-patient clinics, we recommend very earnestly the *establishment of a training center* for medical personnel. This center must be accessible to university instruction and also to field facilities. Any of the existing psychopathic institutes, if provided with out-patient clinic facilities, would be suitable and doubtless would be willing to coöperate.

Every effort should also be made to interest medical students and recent graduates in the field of neuropsychiatry and to place before them the opportunities offered.

Physiotherapy, Occupational Therapy, and Vocational Training

In our recent visits to the hospitals of the service, and also from other experience, we have been much impressed by the need for more exact definition of the terms physiotherapy, occupational therapy, and vocational training. In the hospitals of the service, *physiotherapy* is placed under the direction of a chief of reconstruction, who may or may not be a physician. Physiotherapy, as the name implies, is a form of medical treatment and, just as much as drugs or surgery, it should be prescribed to suit the needs of the individual patient. Furthermore, such prescription should be given by the physician who has charge of the treatment of the patient. Special technicians to carry out the prescriptions are necessary, but they should bear the same relation to the patient and physician as does the nurse or the pharmacist. Nothing is to be gained by appointing a physician to attend only to physiotherapy—no more than would be gained were a physician appointed to attend to the giving of drugs.

It is probable that much of the present confusion is brought about by the fact that many of the physicians know little about the technique of physiotherapy and are therefore diffident in prescribing it. But the solution of this difficulty lies in training the physician. The disabilities of the neuropsychiatric patient, except in the very small group of nerve injuries, are mental and not mechanical. They cannot be treated mechanically as can many disabilities of surgery and medicine. The physician is treating disorders of behavior and his remedies must deal with behavior.

As now practiced, there seems to be but little distinction made between occupational therapy and vocational training. This is not merely of academic interest, but is fraught with the possibility of real harm to the patient, besides the development of conflicts among personnel. The two activities are in reality entirely distinct.

Occupational therapy is not in any sense an effort "to make

something". The purpose with which it is employed is quite variable, as the following classification will indicate. It may be prescribed (a) as a diversion; (b) because it brings into play certain muscles or joints which are functionally damaged; (c) to produce sedation or stimulation; (d) as an education in habits of application. The first two have more place in a general than in a neuropsychiatric hospital, which employs occupational therapy more especially for the last two reasons mentioned.

The *product* of occupational therapy is *the effect* it has *upon the patient.* The articles produced in the process are, like the copy books of the child in the primary-school grades, of no importance. The types of occupation selected are chosen with several things in view: they are interesting; they require a certain degree of steady attention which can be varied by varying the occupation; and they possibly contain elements of technique that may later be useful in industry. They may serve to develop hobbies and recreative interests which will be continued in after life; but the question of the value of the product does not enter. It is therefore decidedly harmful, as well as time-consuming, to insist upon a system of accounting for the articles that are produced. Sometimes destruction of good materials is an important part of the therapy. It is true that many of the articles made can be turned to useful account, and this fact in itself has some value in therapy. But the important point is that the patient is affected by the usefulness, sees the articles in use, uses them himself, or even finds by selling them that he has done something worth while. The value to the government of the articles, which the patient must duplicate if he is to keep one of them for himself, is practically nil.

Vocational training, on the other hand, is a training of the patient to carry out some technical operation and thus to give him a means of earning a livelihood. The *product* is, therefore, *the patient placed in industry.* Articles produced in this process must have a market value, and there is absolutely no place for the merely beautiful, but fancy products, the value of which is personal and largely artificial.

Much of the work being conducted under the name of vocational training in neuropsychiatric hospitals—to which alone

we are referring—is nothing but the routine application of procedures employed in occupational therapy. As a rule, also, they are applied to all alike without consideration of the needs of the patient. This situation is more or less clearly recognized by the workers themselves, and they have introduced the term "pre-vocational training" in order to explain the fact that all that is produced is a beautiful exhibit, while patients are not being placed in industry.

We are convinced that the true explanation of this situation is that there are but few neuropsychiatric patients in hospitals who need, or are capable of, vocational training. These few are the convalescents or those considered to have recovered to the fullest extent possible from the effects of the disease from which they have suffered. It would, therefore, seem desirable to allow the hospital, under the direction of its own physicians, to carry out its occupational therapy up to the point where vocational training is indicated. The patient may then be sent to a training field, still under the supervision of medical officers in the locality of the field; or, if there is a sufficient number requiring the same kind of training, an instructor and aids could be sent to the hospital.

Treatment, Training, and Compensation

There is no aspect of the problem of rehabilitating the ex-service man, except that of medical personnel, that is of such vital importance as the close coöperation between the departments that have to do with treatment, training, and compensation. Perhaps, to one who is not in actual contact with neuropsychiatric cases in a medical way, the logical sequence of events would be to restore the patient to the highest degree of efficiency by therapeutic measures before beginning to train him for some trade or profession in order to establish his economic independence. Under this order of procedure each department would work quite independently of the other and the man would be shifted from one to the other whenever a cross section of the individual indicated the need for a change. However, as all of us who are dealing directly with the ex-service man know, this cross-section method has proved a definite failure. What is needed is a longitudinal section of the patient's life in order that we may consider his past

experiences, his present needs, and his future possibilities. For example, if we are dealing with a mentally deficient individual whose war experiences have rendered him incapable of adjusting himself to his present environment and conditions, although his history prior to the war shows that he got along fairly well in the community, we cannot neglect his present needs, which may mean the actual necessities of life. These, of course, can only be met by compensation; and while future possibilities for this patient may or may not lie in training, certainly in such a case training can be of advantage only if selected after a careful study of the mental equipment and temperamental fitness of the prospective trainee.

The question of who is best fitted, by reason of experience, training, and opportunity, to decide upon the presence or absence of the particular qualities that account for success or failure in an individual is quite debatable, but, other things being equal—that is, intellect and opportunity for observation—it seems that the psychiatrist who has made a study of the particular case is best qualified to advise regarding the type of work for which the individual is best fitted by virtue of his physical and mental equipment, as well as by temperament and disposition.

We very frequently find the man with a mental age of twelve to fourteen years struggling along in some trade or profession that is obviously not within his grasp. The more ambitious and persevering the man, the greater the conflict between his ambition and his achievements, and sooner or later we find him seeking refuge in a neurosis. The same is true when an individual fitted for manual work begins to take up accounting; when the lad who craves outdoor life finds himself shut up in a factory; when the man who is quick and impulsive is forced to do work that requires caution and deliberation; or when the individual who works well under supervision suddenly is thrown into a position that demands responsibility. All of these individual questions must be considered in dealing with problems of vocational guidance.

We do not intend to convey the idea that the neuropsychiatrist should take the place of an expert trained in the problems of vocational guidance, but that he should advise with this expert or furnish him with all the data at hand per-

taining to the prospective trainee's mental equipment and temperamental fitness for general types of work. It seems to us that in this way many of the glaring mistakes that have occurred in the past will be obviated. It may be well to repeat what has already been said elsewhere—that a large percentage of the relapses among the neuropsychiatric cases in training are directly due to their being shunted off into some trade or profession for which they are unsuited.

Much unnecessary time and money may be spent by the government in recommending treatment and training for a certain group of applicants for compensation when it is perfectly obvious that treatment will be of no avail and training is not feasible. The problem of compensation and supervision by some social agency might just as well be met at once. This will allow the applicant to plan his future along practical lines and will not keep him upset by repeated disappointments which tend to aggravate his condition and make his adjustment more difficult. For example, an epileptic first received temporary total disability compensation of $80. In an effort to increase his income, he applied for Federal Board training and was successively placed in a machine shop, a tinsmith shop, a garage, and finally a commercial school. This claimant is an ambitious, earnest sort of chap, of very limited intellectual capacity, and his repeated failures have completely destroyed his morale. Just recently he has been notified that he has a total permanent disability, but his reaction to this, at this period in his dealing with the government, is one of discouragement and discontent. It seems to us that if this situation had been correctly sized up in the first place, this claimant's attitude toward life in general and the government in particular might be quite different.

INFLUENCE OF AFFECTIVE DISTURBANCES ON RESPONSES TO THE STANFORD-BINET TEST*

STEPHEN PERHAM JEWETT, M.D.
PHYLLIS BLANCHARD, PH.D.
Psychiatric Service, Bellevue Hospital, New York

FOR some time after the use of the Stanford revision of the Binet-Simon scale for the measurement of intelligence became one of the recognized factors in the diagnosis of mental deficiency, there was a tendency to consider the intelligence quotient obtained by the use of this scale as comparatively constant for the individual. Terman, in *The Measurement of Intelligence*,[1] stated that there was not one case in fifty in which the I. Q.[2] proved unreliable. He considered it an accurate index of the child's mentality, and his experiments in retesting the same children at intervals indicated that it remained fairly constant.

Further experience with the Stanford scale in the study of children convinced the clinician that in certain cases the I. Q. did not become stabilized over the developmental period (to the age of fourteen or sixteen), but that it sometimes showed great variability as taken at different intervals during this period. Dr. Mateer summarizes the data on this point as follows:

"The I. Q. of the individual child may decrease steadily through the earlier years of childhood, it may stand still, or it may temporarily increase. . . . The situation is still further complicated by the fact that children with comparatively low mental ratings sometimes show an unexpected mental resiliency and rebound toward average endowment in surprising fashion, making up most or all of their lost standing. . . . In consideration of these various possibilities, it seems only

* Acknowledgment is made to Dr. Menas S. Gregory, Director of the Psychiatric Service of Bellevue Hospital, for his kindly criticism and his permission to publish the reports of these cases.

1 Boston: Houghton Mifflin Company, 1916.

2 Intelligence Quotient.

right to insist that a single I. Q., or the findings from a brief examination, be used cautiously as a basis for anything more than a statement of present mental level, unless they are used correlatively with a complete survey of the child from the standpoint of his social, moral, and educational behavior and his environmental, physical, and hereditary handicaps."[1]

Although experience thus taught us to use the I. Q. of the child at any given period discriminatingly as a basis for diagnosis and especially for prognosis, there still remained a tendency to believe that the I. Q. of adults and of the child of average intellectual endowment remained fairly constant. We had learned that the I. Q. of the low-grade feebleminded child dropped considerably as physical age increased, but mental development became more and more retarded and finally ceased before the average limit of development at fourteen or sixteen had been attained. We had learned that the superior child might show spurts of mental development that would tend to raise the I. Q. at different intervals of the developmental period. But because the developmental curve of the average child remained constant under ordinary circumstances, and because the adult was considered to have attained full developmental possibilities, our faith in the reliability of the I. Q. in these types of individuals was for the most part unshaken.

A study made by Dr. Bronner on the effect of the attitude of the subject on the performance of tests should have warned us, even though her data were collected in the use of the 1911 revision of the Binet (made by Binet himself) and supplementary tests, and not with the Stanford revision (made by Terman). Dr. Bronner cited cases in which such factors in the attitude of the subject as deliberate deception, recalcitrancy, sportiveness, and affective disturbances such as anger or resentfulness, depression, homesickness, fear, and the like, materially affected the performance of tests. In all her cases, the level of performance was definitely lowered by the presence of these factors in the attitude of the subject, and better success was achieved upon retesting after the removal

[1] *The Diagnostic Fallibility of Intelligence Ratios.* By Florence Mateer, PH.D. *Pedagogical Seminary*, 25: 369-92, December, 1918.

of distrust, the quieting of affective disturbances, the solution of perplexing emotional conflicts, etc.[1]

In describing the technique of the Stanford-Binet, Terman merely mentioned the necessity of taking into account the attitude of the subject, and in general the literature in clinical psychology bears only casual references to this problem. In spite of Dr. Bronner's study, therefore, many psychologists and medical men have continued to regard the I. Q. as infallible, and have neglected to take into account the affective state of the subject at the time of examination. Occasionally this has led to the commitment as mental defectives of individuals suffering from some affective disturbance, when later examinations, given after the clearing up of the psychosis or emotional disturbance, showed these same individuals to be of normal intelligence. In such cases, there was evidently a failure on the part of the examiner to distinguish between intellectual inability to respond correctly to the problems presented and affective states preventing the subject from bringing his full intellectual faculties to bear on the given task. Terman contends that such a situation arises only in the use of the Stanford-Binet by "untrained and indiscreet examiners".[2] The following case is quoted not only because it illustrates the point under discussion, but also because the psychologist who made the examination is recognized as of thorough training and wide experience.

> *Case I.* First admission, hospital number 38630. L. M. Male, white, 18. Admitted to Bellevue Hospital for observation August 21, 1918. History of school retardation and long history of juvenile delinquency. Charge pending at time of admission. Was confused and deluded, hallucinating, etc. Would not coöperate on tests, so that no psychological examination was made at this time. Exact diagnosis difficult; mixed phase, manic-depressive psychosis or dementia præcox, undecided. He was returned to the Tombs and sent to Matteawan. (Diagnosed as dementia praecox at Matteawan, but subsequent history showed that he was suffering from a manic-depressive attack.)
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> Second admission, hospital number 42969, June 27, 1919. Had been released from Matteawan on a writ of *habeas corpus*. At this time there was little to indicate a psychosis. Patient's behavior on the ward was normal; he helped with the work, etc. There were no gross defects

[1] *Attitude as It Affects the Performance of Tests.* By Augusta F. Bronner, PH.D. *Psychological Review*, 23: 301-31, July, 1916.

[2] *The Measurement of Intelligence*, p. 110.

of memory, orientation was good, no delusions or hallucinations, although there was not full insight into his previous attack. Patient was, however, coöperative in every way. Stanford-Binet showed a mental age of 11-3, I. Q. 70. The summary of the psychological examination read as follows: "The evidence of mental tests is that this patient is on the border line of mental deficiency. He is of very inferior intelligence, yet he is of higher status than the inmates of institutions for the feeble-minded usually are. He might be described as semi-irresponsible, his mental level being between 11 and 12 years. . . . Attitude docile and friendly throughout. No eccentricities of manner noted. Nothing bizarre in his responses."

Third admission, hospital number 44143. Had been released from Matteawan on a writ of *habeas corpus*. His conduct was normal on the ward, etc., and he now had full insight into his previous illness. A second psychological examination showed a mental age of 16+, I. Q. 100+. At this time he was returned to court with the opinion that he had recovered from an attack of manic-depressive psychosis, and was liberated as not insane.

The significance of this case lies in the fact that experienced medical men and trained psychological examiners recognized no affective reactions in the patient of sufficient importance to suggest any doubt as to the accuracy of the results obtained upon the first psychological examination. There was only one slight difference in the clinical pictures at the time of the first and second examinations: at the time of the first test, the patient, although otherwise apparently normal in attitude, had not recovered full insight into his condition, while at the time of the second test, he had complete insight into his previous illness. This case is not an isolated one in our experience. It is obvious, therefore, that the results of intelligence tests made after a psychotic attack cannot be regarded as final until there is absolute certainty that the psychosis has completely cleared and the intellectual faculties are freed for their full functioning. Not only is this true of such marked psychotic affections as that in the case reported above, but it also holds good in milder psychotic states, as the following cases demonstrate:

Case II. Hospital number 52214. F. M. Male, white, 20. Arrested on charge of disorderly conduct. Had been drinking and was emotionally upset. Was sent to Kings County Hospital for observation. A history was obtained which indicated that patient had never been able to get on in school or to take care of himself outside, etc. In view of this history, and the nature of his responses to a partial Binet, patient was transferred to the New York City Hospital at Randall's Island as a mental defective.

July 12, 1921, the psychologist at Randall's Island states: Mental age cannot be determined at present on account of the subject's absolute refusal to answer any questions or touch the performance-test material. He states that he will do nothing until he has his lawyer's advice. . . . Appearance and language of the subject indicate a state of emotional excitement. He complains bitterly of a frame-up at the time he was sent to Kings County Hospital. . . . He gives an impression of dissipation and loose emotional make-up."

July 15, psychological report states: "Patient submitted to an examination only by advice of his lawyer, and attitude throughout the test was one of nervous apprehension. Age 21, mental age 14-2, I. Q. 94. He expresses his embarrassment, but evidently put in his best effort. His account of himself is reserved; although he seems anxious to talk, he is evidently withholding everything which might give a clue to his former life."

On July 16, patient was transferred from Randall's Island to Bellevue Hospital with a copy of this psychological report and a note to the effect that since the examination showed him to be of normal intelligence, he was not a case for the New York City Hospital.

At Bellevue, the patient's attitude was still somewhat suspicious, and he refused to take an intelligence test until assured that we believed him to be normal and merely wanted to confirm the psychological report from Randall's Island. He finally consented to coöperate, although he preceded the test with the remark: "I feel sure that when I finish this, you will railroad me to some institution." He was apprehensive of making errors, and often tried to evade the issue in his replies, or prefaced his responses with some such remark as, "Now I'm afraid this guess may be wrong," etc. Again, he would give two or more responses to the same problem, with the hope of increasing the chance of success. In spite of his anxiety, he made a mental age of 16-7, with an I. Q. of 103.

Case III. Hospital number 44271. E. L. Female, white, 15. Had been under observation at Kings Park Hospital. History of backwardness in school. Reported to have been acting queerly for two months. Had been going to the police station with stories of forging checks, being raped, etc., and had attempted to drink iodine for suicidal purposes. At Kings Park she was diagnosed as a mental defective with a psychotic episode. She was transferred to Bellevue, May 17, 1921, with the statement that her psychosis had cleared and that she was a simple mental defective.

The history of the patient briefly outlined above might be that of an hysterical or emotionally unstable adolescent, or of a high-grade defective. The psychological examination on May 19 would have classed her as the latter. At that time the physical age was 15-8, mental age 11-9, I. Q. 75. The examination was summarized as follows: "By the rating of the test alone, the patient would class as of border-line intelligence. Basic year 9 and group limit 14 years. Is unable to give a clear account of why she is here." There was nothing to indicate that the test did not fairly represent the patient's intellectual level. The performance was evenly distributed, etc., and patient stated that she had had the same examination at Kings Park. However, it was considered wise, in

view of her emotional instability, to check up the results by a second examination. On May 24, a second Stanford-Binet was given. The mental age was now 12-6, I. Q. 79, a rating that would still class her as a border-line type. It was significant, however, that the basic year had progressed from 9 to 10, and that there were more successful responses at the 12- and 14-year levels. At this time, patient was obviously worried and anxious, and a note was made to the effect that possibly the tests thus far given were not representative of her real ability.

Shortly after the second test, the patient attempted abortion by putting safety pins in the vagina. She explained that she believed herself to be pregnant. Further explanation and examinations revealed the fact that she had never had intercourse, and that her fear that she was pregnant was based on ignorance of the biological facts of conception. When this matter was made clear to her, her attitude became less anxious. A third Stanford-Binet was given on June 9. This time, the mental age was 13-1, I. Q. 83. The basic year was still 10 and the group limit 14 years, but there were more successes at the higher levels, and her attention, effort, and general coöperation were much improved. The rating of this last examination, while perhaps still below her actual capacity, was sufficient to class her as of normal intelligence. She was diagnosed as a case of psychic constitutional inferiority with a psychosis, and returned to Kings Park.

Case IV. First admission, hospital number 41046. D. K. Female, white, 16. Admitted to Bellevue Hospital for observation May 16, 1920. Was charged with immorality and running away from home. Prior to her admission, she had been in charge of the S. P. C. C. for about two weeks. Was reported to have been "hysterical" during that time, using vile language, destructive, hiding knives in her clothing, etc. At Bellevue, her mood alternated from a mild elation with restlessness and flightiness to periods of inactivity and mild depression. These symptoms were not sufficiently marked to warrant her commitment, and she had intervals of appearing practically normal. The Stanford-Binet, given May 23, rated her at a mental age of 12 with an I. Q. of 75. The summary of the psychological examination read as follows: "The evidence of mental tests is that this patient is of inferior intelligence, but not sufficiently low on the scale to be technically termed mentally defective. Technically she would be described as of 'border-line' intelligence. Patient is confiding to the point of being somewhat garrulous. Her performance is consistent in revealing a low grade of ability, not quite reaching the level of a moron."

Inasmuch as the patient improved to a marked extent and her symptoms were not sufficiently severe to warrant commitment to a hospital for the insane, the psychological test was considered accurate and the patient was returned to the S. P. C. C. on May 29, 1920, as a case of border-line mental deficiency.

Second admission, hospital number 45742. Admitted to Bellevue Hospital for observation October 28, 1921. Transferred from the Loeb Convalescent home because they considered her nervous and in need of treatment. Was restless for the first hour or two after admission, but soon became quiet. During her stay, her conduct on the ward was normal

and her attitude was agreeable. A Stanford-Binet was given November 9, and she made a mental age of 15 years, 3 months, with an I. Q. of 95. The psychological summary was as follows: "By the rating of the examination, the patient would class as of normal intelligence. Basic year 10 and group limit 18 years. Attention and effort good. Both rote and logical memory are excellent. Judgment fair."

It is certain that in at least one of these three cases (Case IV) the erroneous impression formed on the basis of the psychological examination was not due to inexperience or lack of discretion on the part of the examiner, who was one of the best trained and most widely known in the profession.

The cases reported above, and similar instances that came under our observation, brought forcibly to our attention the effect of emotional disturbances on the responses to the Stanford-Binet, and raised the question as to the accuracy of the I. Q. in many types of patient encountered in a psychiatric service. Once interested in the problem, we found that not only affective tensions due to severe psychoses and mild psychotic states affected the reactions to the Stanford-Binet, but that emotional disturbances due to organic lesions, use of drugs, etc., and even ordinary affective reactions such as the average individual shows under stress, tend to interfere with the concentration of the full power of the intellect, through defects of attention, association, etc. This is expressed not only in the type of reaction to the situations presented in the course of the examination, but also in the final result as represented by the I. Q., which is often materially lower than the actual intelligence level of the individual as indicated by the I. Q. obtained when the emotional blocking is removed and attention, association, and the other intellectual faculties are free to function at the highest level of efficiency.

In many instances, the experienced clinician is enabled to suspect from the manner of response that some emotional blocking is preventing the patient from making the best possible rating on the intelligence examination. An extremely scattered performance on the Stanford scale, in which the subject is successful at one or more higher year levels after having failed signally on one or more preceding lower years, almost invariably indicates affective blocking of some kind.

Slowness of response, necessity for repetition of instructions in order to elicit any reaction, irrelevant responses which indicate disordered associative processes rather than failure to comprehend the given situation, tendency to continued elaboration of the response to a preceding situation which interferes with the transference of the attention to the next problem presented, reaction to a situation in harmony with instructions given in connection with previous situations (perseveration)—these and other peculiarities of behavior should lead one to suspect the accuracy of results, because they are symptomatic of affective disturbances which interfere with intellectual accomplishment, even though the patient appears to put forth much effort on the examination. Indeed, this very intensity of effort is necessitated by the affective blocking, since the patient must make an unusual exertion in order to overcome it and answer at all coherently.

In cases where there is a lesser degree of emotional disturbance, even the trained psychologist may fail to recognize its existence. These are cases in which there are no peculiarities of behavior or reactions to the examination to be noted, so that the affective disturbance is realized only after some change in the patient's general conduct on the ward is noted, or some other indication of a change in emotional state is observed. This is particularly apt to hold true in the emotionally unstable type of individual whom we class as of "psychic constitutional inferiority". The following cases show the desirability of repeated examinations in such cases, and the danger of relying on one test alone:

Case V. Hospital number 44016. M. P. Female, white, 14. Patient was transferred to Bellevue from the Cedar Knolls School because of her continual efforts to escape from that institution. She had been committed to Cedar Knolls as a "disorderly child" on January 17, 1921, and was transferred to Bellevue on April 18. The history reported from the school records would lead one to expect a high-grade mental defective or border-line type, and the first examination by the Stanford-Binet appeared to confirm this expectation. On April 20, patient made a mental age of 9-9, I. Q. 69. The basic year was 7 and the group limit 14 years, with a fairly even distribution of performance. The note on the examination read: "By the rating of the test alone, the patient would class as a border-line case of mental deficiency unless medical examination shows some other reason for her retarded development. Attention and effort good. Very reticent about herself. Gives impression

of being able to do better than results of test show. Very nervous.'' At that time, the examiner did not regard the fact that she gave the impression of being brighter than the test indicated as an indication for retesting, but simply noted it as a part of the clinical picture, considering it a deceptive impression produced by the patient's nervous vivacity.

By April 30, patient appeared less nervous and was quicter on the ward, so that another examination was considered advisable. She now made a mental age of 12-6 with an I. Q. of 88, which would class her definitely as of normal intelligence. Her basic year had progressed to 9, and she was much more successful at the 12- and 14-year levels. She was returned to Cedar Knolls with a diagnosis, not of mental deficiency, as might easily have been the case had only one test been relied upon, but as a case of psychic constitutional inferiority.

Case VI. Hospital number 52162. C. S. Male, white, 15. Brought before the Brooklyn Children's Court on the charge of ungovernable child and sent to Bellevue for observation July 12, 1921. History of dullness in school, general disobedience, etc., such as is often given in the histories of mental defectives. Was examined by the Stanford-Binet July 14. Physical age 15-8, mental age 11-7, I. Q. 72. Basic year was 7 and group limit 16, with more successes at the 14-year level than at the 12-year level. This unevenness of performance, although so slight as to be little cause for suspicion, nevertheless led to the giving of a second examination. On July 27, patient made a mental age of 13-2, I. Q. 84. The basic year was now 10. The change in rating was sufficient to raise the patient from the border-line to the dull-normal class in intelligence. Other reasons than intellectual defect were found for his delinquent conduct, which might easily have been attributed to border-line mental deficiency had only one Stanford-Binet been given.

Case VII. Hospital number 4537. G. K. Female, white, 18. Admitted to Bellevue for observation September 21, 1921. Was sent from the Catholic Protectory with the following report: ''We are sending you in care of the bearer the girl G. K., recently examined and diagnosed a mental defective, but returned to the institution. We are advised by our Rev. Sister Superior that the girl is a continual source of trouble due to the fact that she persists in conducting herself in the most erratic manner and resists all efforts to check her peculiar behavior, which has a demoralizing influence on the other inmates. She was placed in a foster home some time ago, from which she had to be removed because of her propensity for seeking the companionship of young men, . . . etc.''

The psychological examination which had previously been made in clinic rated the patient at a mental age of 10 with an I. Q. of 62. The summary of the examination read as follows: ''Coöperated in a friendly manner. Is somewhat emotionally unstable; shows a good deal of variability in her intellectual development. Gaps that reveal a decided mental defect. Her memory is variable; also her judgment and the other so-called higher mental functions are imperfectly developed. She is the type of girl who should have careful supervision always. . . . Moron grade.''

After being on the ward, the patient was given another Stanford-Binet, as her conduct, although disobedient, etc., was not such as to indicate any great mental deficiency. The second examination, which was made September 22, 1921, gave the patient a mental age of 10 years, 2 months, with an I. Q. of 63. The summary of this examination read as follows: "By the rating of both this and the previous examination the patient would class as mentally defective. She is apparently somewhat nervous and emotionally unstable, however, and it is not safe to assume that the tests represent the highest possible rating which she is capable of making, although it is doubtful if she could go above the border-line group at best."

In view of the close rating on the two tests made by two different examiners, both experienced in the work, and the patient's history of improper behavior, etc., she was transferred to the New York City Hospital at Randall's Island as a mental defective, pending admission to the State School at Newark, to which she had been committed. At Randall's, after some time had elapsed, a third Stanford-Binet was given on November 21, 1921. The patient's conduct was reported to have improved; she gave the impression of being much more stable emotionally, etc. At this time she made a mental age of 12 years, 4 months, with an I. Q. of 82. On the Performance Scale she made a still higher rating. The rating of these last tests was sufficiently higher than the first two to raise the patient from the high-grade-moron group to that of normal intelligence.

These three cases are chosen from several similar ones that have come under our observation because they are deceptive in that there is very little in the nature of the examination itself to lead the clinician to question the accuracy of the first rating obtained. In view of the unstable emotional make-up of this type of patient, however, we should not be surprised, once we have realized the effect of emotional blocking upon intellectual effort, to find that the I. Q. varies considerably from time to time. The necessity for caution in diagnosing these individuals as mentally deficient upon the evidence of a single examination cannot be overemphasized.

After we have learned by experience to be exceedingly careful in our acceptance of the ratings of intelligence tests upon psychotic and emotionally unstable patients, we still encounter other types which are quite as deceptive. When a child who appears very dull and has a school history of retardation and truancy rates as mentally defective on the intelligence test, the rating is so in harmony with our expectation that we naturally do not question its accuracy unless there are exceptionally peculiar reactions and behavior. We

have had one such completely deceiving case within the past year.

Case VIII. Hospital number 50810. P. S. Male, white, 11. Admitted to Bellevue Hospital March 29, 1921. Had been taken to the children's court on account of improper guardianship. In physical appearance he was undersized, poorly built, etc. Looked more like a child of 7 than of 11. History of never liking school and never being able to learn. He often played truant. Was in grade 3A. Was able to read a little, but could not write. Had twice stolen money given him to buy things with. Had stayed away from home two nights. Stanford-Binet given on March 30. Physical age 11-2, mental age 7-10, I. Q. 70. Performance evenly distributed from the basic of 7 to the group limit of 9 years. There was complete failure at the 10- and 12-year levels, which were both given. The boy's attitude was dull and indifferent. The summary of the examination read: "By the rating of the test, the patient would class as mentally defective, border-line type. His school history of truancy and retardation bears out this conclusion."

A medical examination revealed that the patient was undernourished and that he was also suffering from dispituitarism, and he was accordingly put under treatment. At the time of the medical examination, his conversation led the examining physician to question the diagnosis of mental deficiency. On April 8, a second test was made. Physical age 11-3, mental age 8-8, I. Q. 77. Although the increase in the I. Q. was slight, there was a noticeable difference in the distribution of performance, the group limit being raised from 9 to 10 years. The rating on the second test still classed him as a border-line type, although bringing him nearer the line of normality.

The third examination was made May 18. Patient was now in much better condition physically, and his emotional reactions were more natural. In place of his former dull, listless attitude on the ward, he was now playing with the other boys, was full of all kinds of pranks, and manifested affection for the nurses and doctors. At the time of this third examination, the physical age was 11-4, mental age 9-3, I. Q. 81. Although this rating placed him among individuals of normal intelligence, once again the change in distribution was more striking and more significant than the change in the I. Q. The basic year remained at 7, but the group limit had advanced to 14 years. Certain difficult problems, such as the detection of absurdities of the 10-year group, were now answered correctly, although they had been failed in both previous examinations.

It is probable that in this case the patient's physical condition underlay his emotional attitude of indifference and lethargy, and that as his physical condition became more normal, his affective life also progressed toward normality. The intellectual effort, in turn, being freed from emotional blocking, became correlatively efficient. Other cases came under our observation in which physical condition and emo-

tional tone were improved with concomitant raising of the rating of the Stanford-Binet, but in these other instances there was a history of previous illness which naturally induced the examiner to make only a tentative statement as to the findings on the intelligence test. The significance of the case reported lies in the fact that there was no medical history which would indicate that the boy's attitude at the time of the first examination was other than the ordinary dullness of a mentally defective child. Indeed, it was only the marked change in his attitude on the ward that indicated the necessity of a third examination, as the medication for his condition of dispituitarism had not been continued sufficiently long to lead to any expectation of improvement as a result of medication.

Perhaps the medical history that should most be regarded as indicating that the results of intelligence tests cannot be considered accurate is that of post-encephalitic conditions. The early convalescence from this disease is often characterized by a phase of indifference, poor memory, defective attention, etc., which simulates the clinical picture of feebleminded-ness to a considerable degree. Thus, one boy, six years of age, was brought from the children's medical ward, just before his discharge after an attack of encephalitis, for an intelligence examination. He rated decidedly below the border line of mental deficiency on the Stanford-Binet, but the examiner declined to make a definite diagnosis or prognosis in the case, feeling that too little was known of the effects of the disease to state whether the low rating on the test was due to primary deficiency or to the effects of the encephalitis, and if the latter, whether there was hope of improvement. On June 1, 1921, the same patient was brought into the observation ward because of persistent running away from home. An intelligence test given June 28 gave him a mental age of 6-2, with an I. Q. of approximately 100. This made it evident that the low rating on the first examination was due to the effect of the encephalitic infection, and that marked improvement had taken place during the three or four months since the first examination. Other cases of encephalitic convalescents who were under observation showed similar improvement upon repeated testing. The following

case is worthy of report as fairly typical of what the psychologist may expect to find in testing encephalitic convalescents:

Case IX. Hospital number 49871. J. E. Male, white, 9. Admitted to Bellevue Hospital January 26, 1921. On admission was dull in attitude, did not play with other boys, seemed indifferent to surroundings, and rather stupid in general. The only apparent emotional reaction was one of timidity. When given the Stanford-Binet on January 28, this timidity was marked, but no other peculiarities of reaction were noticed except that his performance scattered over the scale from a basic year of 4 to a group limit of 9 years. Physical age 9-9, mental age 6-4, I. Q. 66. But for the history of encephalitis and the possibility that his fearful attitude prevented him from making his best rating, he would have been classed as definitely feebleminded.

On February 7, patient was retested. His attitude on the ward had changed. He now played with the other boys, showed an interest in his surroundings, and was no longer fearful. Physical age 9-9, mental age 7-6, I. Q. 77 on the second examination. The basic year had progressed to 6. A third test was made March 11 and showed still further improvement, as did his behavior with the other boys. He now had a physical age of 9-10, a mental age of 7-10, and an I. Q. of 80. The basic year was now 7, although the group limit did not advance beyond 9 years.

Shortly after this third examination, patient was taken home by his parents. It is probable that could another test be made, he would show even greater improvement. It is certain that while he was under observation the emotional and intellectual changes were obviously correlated, and that as the emotional reactions became more normal, the ability for intellectual effort improved also.

In addition to those groups of individuals with psychotic or emotionally unstable make-up, in whom a fluctuation of the I. Q. is to be expected, and of organic cases in which there is a temporary impairment of the intellectual functions, as in post-encephalitic states, there is another class of patients in whom the findings of the intelligence test must be regarded with caution. These are individuals who have become addicted to the use of drugs, and who are examined when suffering from withdrawal symptoms or just after a cure. Tests made on a group of girls at the Bedford State Reformatory, who had a history of drug addiction just previous to their admission, showed a marked increase of the I. Q. taken after they had been in the institution a year or more as compared with the I. Q. taken just after admission. In several instances, the variation was sufficient to raise them

from the class of high-grade moron or border-line intelligence to normal intelligence. This is not surprising when we contrast the emotional irritability of the newly cured addict with the greater emotional poise of the addict who has been off the drug for a period of several months.

We find a similar difference in the I. Q.s taken during withdrawal and after administration of the drug, just as we find a state of affective tension and general irritability when the individual is undergoing withdrawal symptoms, and a state of contentment and emotional satisfaction when the craving has been satisfied. This is well illustrated in one of our recent cases, which is typical for the group of drug addicts examined.

Case X. Hospital number 53069. R. R. Male, white, 28. Arrested on the charge of unlawful possession of drugs and sent to Bellevue Hospital for observation September 19, 1921. Began using drugs three years ago. At first used morphine intermittently, and had used heroin regularly for about a year. When examined by the Stanford scale, September 20, was irritable and restless, asking for relief. Coöperation was secured by promising him morphine if he would try his best on the test. At this time he made a mental age of 12-9, I. Q. 79. The basic year was 8 and the group limit 16 years. The performance was fairly even, except that there were more successful responses at the 12- and 14-year levels than at the 10-year level.

On September 23, shortly after the patient had been given a hypodermic of 10 minims of Magendie's solution, a second test was made. His attitude was now one of affective satisfaction; he talked pleasantly, smiled, and appeared fairly contented. This time the mental age was 14-7 and the I. Q. was 91. The basic year had progressed to 12 and the group limit had advanced to 18 years. This change in rating was sufficient to raise the patient from the class of border-line to normal intelligence.

Besides affective disturbances that may be traced to some pathological source in the personality make-up, organic disorders, use of drugs, etc., the ordinary emotional reactions that any person naturally displays under certain situations may also have a definite influence on the response to intelligence tests. The fear and anxiety that naturally result from being brought into a hospital ward or taken to a courtroom are the reactions most often encountered, and many cases show the effect of the apprehensive attitude thus induced upon the ability to answer correctly the problems presented in the psychological examination.

Case XI. Hospital number 44573. M. C. Female, white, 14. Admitted to Bellevue Hospital June 17, 1921. Sent for observation from the children's court, where she had been taken on account of improper guardianship. Was considered feebleminded at home, was only in the third grade at school, had not been able to learn to read. Was tested by the Stanford-Binet, June 21. Physical age 14, mental age 7-4, I. Q. 52. The basic year was 6 and the group limit 9 years. The performance was fairly regular and even, but responses were difficult to obtain, and there was a tendency to smile incongruous with the external situation, etc. This peculiar behavior suggested that some other factor than simple primary amentia was to be sought. The impression was that the patient was suffering from some mental disorder, perhaps an incipient form of dementia praecox, superimposed on a defective basis.

A few days later, the examiner succeeded in winning the patient's confidence to some extent, and she admitted that she was afraid to say or do anything while in the hospital, lest she give the impression of being foolish or insane, as her people had for some time been trying to have her committed to some institution. It was explained to her that the easiest way to avoid permanent commitment was to answer the questions asked to the best of her ability. The test was then repeated, June 27. This time the mental age was 10-4 and the I. Q. was 73. The basic year remained at the 6-year level, but there were more successful responses at the 8-, 9-, and 10-year levels, and one of the 14-year problems was answered correctly. The patient's fearfulness was not completely removed at the time of this examination, and it is probable that this rating did not do full justice to her actual capabilities.

Case XII. Hospital number 52199. J. W. Male, white, 8. Patient was first seen in the mental clinic July 15. His aunt brought him to the clinic, complaining of his conduct. She stated that he masturbated continually, lied, stole money from her, etc. He was in the first grade at the Sisters' school. The Stanford-Binet gave him a mental age of 6 with an I. Q. of 75. The performance was exceedingly scattered, ranging from a basic year of 3 to a group limit of 10 years. The distribution was uneven, the 8-year problems being failed completely. This uneven performance, together with a certain peculiar hesitancy in the boy's manner, led the examiner to question the reliability of the I. Q. obtained, and he was admitted to the ward for further observation.

On July 18 patient was retested. The mental age was now 6-10, I. Q. 85. The performance was still scattered and uneven, and there were evidences of emotional disturbance, so that it was probable that this rating was also below his real intelligence level. It was high enough, however, to demonstrate that the source of his difficulties was to be sought in other causes than primary mental deficiency, although his history and the rating of the first examination would have pointed to this explanation.

Case XIII. Hospital number 50378. L. M. Male, white, 17. Arrested on the charge of sodomy and admitted to Bellevue Hospital for observation March 2, 1921. Public-school graduate, and had been to high school a year and a half. Stanford-Binet was given March 3. Mental

age 10, I. Q. 62. Basic year 7 and group limit 12 years. Effort and attention appeared to be good, but the rating of the test was so little commensurate with his school history that a second test was considered advisable. When retested March 7, he admitted that he had not been able to keep his mind on the preceding examination because he was so worried about his situation. It was evident that he was still anxious, and that this interfered with his responding to the best of his ability. He now made a mental age of 12-4, with an I. Q. of 77. The basic year was still 7, but the group limit was raised to 18 years and there were many successful responses at the 14- and 16-year levels. The conclusion was reached that the boy was of normal intelligence, but that his anxiety and preoccupation with his own troubles prevented him from making a higher rating on the examination.

Case XIV. J. F. Male, white, 29. Admitted to the prison ward of Bellevue Hospital, May 19, 1921; charge, murder, first degree. Was given the Stanford-Binet June 8, 1921. Mental age 4-6, I. Q. 28. Basic year 3 and group limit 7 years. Stated that he went to school to "about the third reader". Was able to read only simple words, and said he could write only his name. He refused to sign his name, however, explaining that he was now in trouble because two men had forced him to sign his name to a paper which he was unable to read. "I didn't hurt any one. I only signed a paper." There were strong evidences of fear in his attitude other than this peculiar behavior when asked to write his name, so that it was considered advisable to repeat the psychological examination. The second test was made June 18. This time the mental age was 7 and the I. Q. 43. The basic year had advanced to 5 and the group limit to 9 years. The performance was evenly distributed. It was unlikely that so low a rating could be due to emotional disturbance alone, although it might be that there was still some emotional blocking. The patient's attitude on the ward, his childlike, simple demeanor, his school history, inability to read and write, etc., were all in harmony with a diagnosis of mental deficiency, so that the second test was accepted as an approximate index of the patient's intelligence.

It will be apparent, when the last case is compared with the others reported in this paper, that the necessity for careful diagnosis is in those cases where the first rating is indicative of high-grade moron or border-line mental deficiency. In the cases reported, the increase in the I. Q. varied from 10 to 20 points. Such variation is of no especial importance for general diagnostic purposes in the case of low-grade feebleminded individuals. For example, if a patient makes a rating on one test of an I. Q. of 28 and then makes an I. Q. of 43 on a second test, as happened in Case XIV, the diagnosis of mental deficiency is unaffected by this change in rating although it amounts to an increase of 15 points in the

I. Q. But when the I. Q. is raised 20 points, from 69 on the first examination to 88 on the second, as was true in Case V, the diagnostic significance is fairly obvious, since a person with an I. Q. of 69 would be considered as mentally deficient, while one with an I. Q. of 88 would be considered of normal intelligence. With the possibility of fluctuations in the I. Q. of from 10 to 20 points as a result of emotional blocking, this possibility must be taken into account in summing up the psychological findings in subjects of high-grade or border-line rating on the examination.

The cases reported in this paper suggest certain important points that must be taken into consideration in determining the reliability of the I. Q. in border-line types. These may be briefly enumerated as follows:

1. During a psychosis, an I. Q. is without value as a representation of the actual intellectual capacity of the individual.

2. The I. Q. obtained after a psychotic attack can be regarded as only tentative until sufficient time has elapsed for all emotional disturbance to have subsided and for the patient to have regained full insight into his condition.

3. In individuals of emotionally unstable make-up, usually designated as cases of psychic constitutional inferiority, two or more tests are indicated when the rating on the first test would rank on the border line of normal intelligence.

4. In cases where there is a medical history of organic illness, such as encephalitis, etc., the I. Q. cannot be considered an accurate indication of the patient's original intellectual endowment.

5. The I. Q.'s obtained on drug addicts are subject to fluctuation with the state of the patient in reference to the use of the drug—whether in withdrawal, recently cured, etc.

6. Even such slight emotional disturbances as the anxiety and fear aroused by unusual surroundings may cause an affective blocking that renders the I. Q. taken at such a time inaccurate.

7. No I. Q. should be taken as final when there is a scattered and uneven distribution of performance or when any peculiarities of response—such as slow reaction time, necessity of repeating instructions constantly, irrelevant associations, etc. —are observed.

8. In cases in which the history, clinical picture, conduct on the ward, etc., fail to harmonize with the rating of the test even to a slight degree, a second test is always indicated.

9. It cannot be too strongly emphasized that not the I. Q. alone, but the whole clinical picture, past history, etc., must be taken into account in deciding the intelligence level of the individual.

STATE CARE, TRAINING, AND EDUCATION OF MENTAL DEFECTIVES

PEARCE BAILEY, M.D.

Chairman, New York State Commission for Mental Defectives

THE provisions for mental defectives, once the public grasps the importance of them, are destined to become an exclusive function of each individual state. The same reasons that have proved valid for the state care of the insane exist for the state care of defectives. The program is complicated, involving the coöperation of many different departments, such as various courts, boards of education, etc.; it is extended, and is especially important in rural communities where mental defect has a wider distribution than in cities or towns. It demands a central agency, competent to function over the whole state. As no state has as yet adopted an adequate program, it may be useful at this time to offer a contrast between present methods, and a plan by which state care might be carried out, and also to mention some of the methods that are in use in New York.

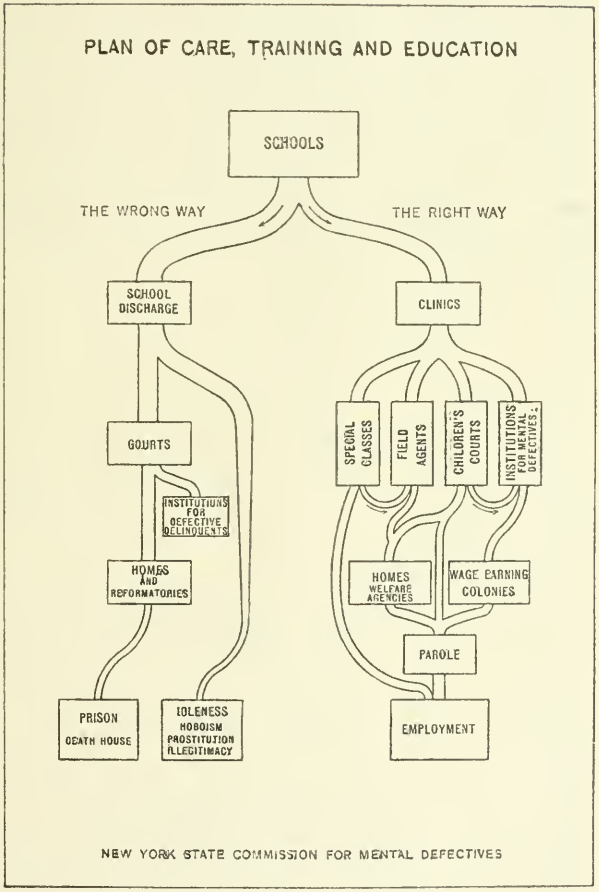
The beginning, of course, is in the schools. It is in them that the mental defective inevitably comes to light, and it is during the school years alone that constructive efforts have some chance of being successful. Of the one million children in that river of promise flowing through the schools in the state of New York, let me say forty-five thousand are diverted from the main current because of defective intelligence. Unable to fulfil the requirements as laid down by educational departments, the bulk of this forty-five thousand are excluded from the schools at an early age and are lost track of; a small proportion of the total are provided with special facilities in the schools in limited classified groups, or are taken care of in other ways. These latter special provisions are, obviously, the humanitarian, and in the long run perhaps the truly economical, way for the state to discharge its responsibility toward these handicapped children. The other way—namely, that of throwing out on their own resources those who are constitutionally incapable of taking care of

themselves or of learning how to do so without special instruction—is the Wrong Way. Unfortunately the Wrong Way is the one most in vogue everywhere. The diagram (page 59) shows the various stops in the two ways of dealing with this stream of defectives passing out from the schools and the end results of the two ways of stemming the current.

On being diverted from the great river of normals, the stream of mental defectives divides, one branch turning into what might be called the Valley of Despair, the other into the Valley of Hope. Poetic expansion having no place in a diagram, these valleys are denominated the Wrong Way and the Right Way. As the Wrong Way is always the easiest, let us follow it first.

Along it the first stop is *Discharge* of defectives from school—exclusion from all it can give—because they have shown themselves to be unable to profit from the classes, or for other reasons. Coördinate attempts at betterment by state or municipal authorities cease at this point. The children, fundamentally incapable and without education or training, are released from all care, supervision, and control, except such as they may find in their homes, when they have any. It would be inconceivable for physical cripples to be treated as so many of these mental cripples are treated. After quitting the schools, this dark, deep stream divides again, one good-sized branch soon reaching the courts, criminal, children's, and juvenile, the other flowing on to periodic employment or to idleness and all it implies in the way of prostitution, illegitimacy, hoboism.

Eddies and whirlpools churn in the *Courts*. There the same thing happens over and over again. If the children are serious delinquents, the real cause of the delinquency is not always perceived, and in fact there would be little practical purpose in perceiving it except when special *Institutions for Defective Delinquents* exist. These institutions are planned to provide opportunities for long observation and training, with the purpose and hope of eradicating in time the bad habits acquired through years of parental and state neglect of those feebleminded boys and girls who, having little will of their own, are suggestible and imitative. It is believed that


PLAN OF CARE, TRAINING AND EDUCATION
SCHOOLS
THE WRONG WAY
THE RIGHT WAY
SCHOOL DISCHARGE
CLINICS
COURTS
INSTITUTIONS FOR DEFECTIVE DELINQUENTS
HOMES AND REFORMATORIES
SPECIAL CLASSES
FIELD AGENTS
CHILDREN'S COURTS
INSTITUTIONS FOR MENTAL DEFECTIVES
HOMES WELFARE AGENCIES
WAGE EARNING COLONIES
PAROLE
PRISON
DEATH HOUSE
IDLENESS
HOBOISM
PROSTITUTION
ILLEGITIMACY
EMPLOYMENT
NEW YORK STATE COMMISSION FOR MENTAL DEFECTIVES

most juvenile offenders who are such by reason of defective mentality would turn out quite differently if they had been started in the stream that flows the Right Way. Thus, institutions for defective delinquents, while indispensable as things are at present, are nevertheless placed in the chart on the wrong side. The imperative need of such stopping places to absorb some of the stream that flows the Wrong Way has been recently demonstrated in New York. The legislature of 1920-21 set aside the plant at Napanoch for the custody, care, and training of male defective delinquents over sixteen years of age, the first institution of the kind established in the United States. It opened its doors June 1, 1921, and on November 1 of the same year it had reached the capacity appropriated for it.

The courts make the best disposition they can of the cases that surge through them, utilizing the reformatories of the state and the many excellent homes provided by private charity. But in none of these institutions are there any procedures specially devised to educate and train defectives, and even if there were, the length of time that defectives remain in them is too brief to convert the badly brought up feebleminded into useful citizens. So a certain proportion reach prison at last, where they constitute approximately 12 per cent of the population.

In the *Prison* stop of the diagram, the "Death House" is bracketed. This might seem to impart a sensational note to the diagram were it not that defectives actually are put to death now and then. Two died in this way in Sing Sing in 1920, neither of whom had a mentality to equal that of a child of nine years, neither of whom had ever had intelligent supervision or training. It almost seems as if, in exacting the full penalty from these children, the state were directing attention away from its own thoughtless neglect of them.

The greater volume, however, of defectives do not come into serious conflict with the law. They are poured from school into a great stream which flows, it would seem, for much of its course underground, so little is known of the individual fate of the elements that compose it. Some of this stream is absorbed by the community, for the purpose of unskilled

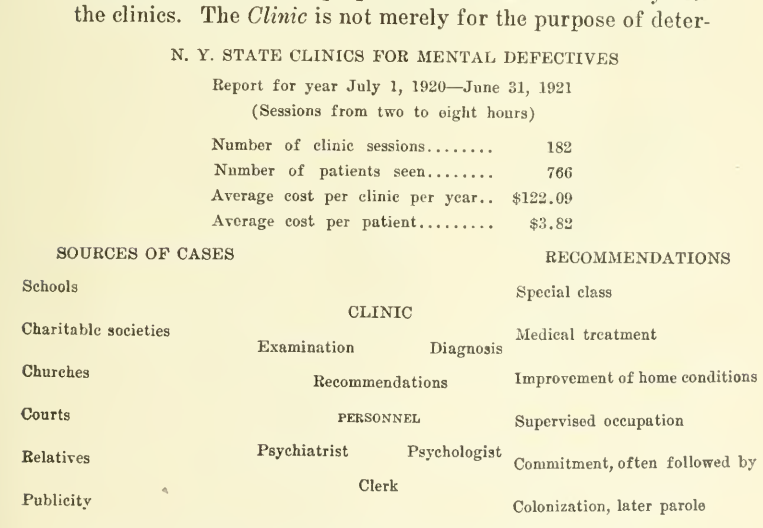
labor, especially in times of economic activity. For example, during the recent shortage of labor, applications for admission to institutions for mental defectives, heaped desk high in ordinary times, almost disappeared. But in the end this underground stream comes to the surface, appearing as prostitution, destitution, and various forms of unemployment.

The Right Way is the channel now being dug in the state of New York and in a few other states. With an increasing realization of the importance of mental defect in the matter of education, public economy, and contentment, it will be deepened and widened year after year. Along it the stream of those who cannot keep up in the schools flows directly into the clinics. The *Clinic* is not merely for the purpose of deter-

N. Y. STATE CLINICS FOR MENTAL DEFECTIVES

Report for year July 1, 1920—June 31, 1921
(Sessions from two to eight hours)

Number of clinic sessions.....	182
Number of patients seen.....	766
Average cost per clinic per year..	$122.09
Average cost per patient.....	$3.82



mining the degree of mental defect with a view to deciding whether or not institutional care is desirable. It has a much more constructive function. Many children, wholly incapable in the class room, get along very well with occupations involving the use of the hands. One boy in a New York public school, unable to learn to read or write, was found to assemble gas engines skillfully. Before that, he had always been in trouble, and had been constantly shunted from one school to

Cities in New York State in which examinations for mental defect are made under the supervision of the State Commission

another; after that, he begged to be allowed to work long after school hours and no trace of delinquency remained. The clinic, therefore, tries to effect adjustments and also determines the presence of physical defects, prescribes means for correcting them, and refers children to appropriate agencies. Clinics may be anywhere—in the schools themselves, in the courts, or functioning independently as special dispensaries. The map (page 62) shows the location of this latter type of clinic in the state of New York. All the clinics administered by the New York State Commission were organized by Dr. W. C. Sandy, late psychiatrist to the commission. In fact Dr. Sandy organized these clinics so well that his talents were recognized by the Department of Public Welfare of Pennsylvania, by which he has been called to take charge of the Bureau of Mental Hygiene.

Special or *Ungraded Classes* are intended to supply to defectives living at home the kind of education that will prove most profitable to them in the end. They are the day schools, as the institutions are the boarding schools. They operate to greatest advantage in conjunction with clinics, and in most of the large cities, the only places where they exist, special classes maintain their own clinics.

Field agents are a recent creation and are destined to become an important feature of any state program. They can materially increase the number of institution beds available.

In New York the Civil Service requirements for field agents are that they be from twenty-five to fifty years of age with experience in the application of psychometric tests, special credit being given for practical experience in teaching, institutional, or social work. These agents were intended primarily to keep in touch with defectives after they leave the special classes, for the purpose of insuring that all the teaching and training received should remain a permanent asset to the child. But field agents have developed many functions besides those at first contemplated. They assist at the clinic examinations and afterwards instruct the parents at home as to the means of taking care of the children. The children they deal with particularly are those excluded from the schools on account of low mentality, and mentally defective truants. In many

cases the field agent obviates the necessity of institutional treatment. This effects, satisfactorily, a substantial saving for the state, as the per capita cost of institutional care is $336.42 as compared with $8.90 for supervision at home. This becomes of special importance in view of the fact that most of the cases referred to field agents are of low mental grade, so low that the parents would be obliged to send them away unless specially encouraged and instructed how to keep them at home.

Children's Courts, especially when provided with clinics, are indispensable to any program for mental defectives. They maintain an effective probation (parole) system, thus providing the supervision which is vital in the care of mental defectives. They are important distributing agents. In New York City one half the cases that come to these courts are cases of "improper guardianship", under which circumstances the court is called upon to indicate proper surroundings. Such surroundings are found in many private homes and, when there are vacancies, in the state institutions for mental defectives. In New York City alone there are 1,800 known cases that should be in state institutions. Neither the *Children's Courts* nor *Special Classes* are directly connected with the New York State Commission for Mental Defectives, but all work in harmony and should grow closer and closer together.

It will be observed that all the stations so far mentioned as being situated along the Right Way are not permanent stopping places, but points through which the stream of defectives flows. In the *Institutions for Mental Defectives* the stream slows up inevitably and deposits a sediment, a permanent, unchanging population which remains in the institution till it dies. Formerly the reception and maintenance of this sediment was considered the chief, if not the sole, function of these institutions. They were custodial mainly, if not wholly, and one might almost have imagined over their portals the same legend that so overwhelmed Dante, when he set out on his famous trip underground.[1]

But to-day hope, even within these somber institutional

[1] *Lasciate ogni speranza, voi che entrate.*

New York State Institution for Defective Delinquents at Napanoch, created 1921

Selected inmates being prepared for parole, Syracuse (N. Y.) State School

walls, is not dead, for a certain proportion of the inmates can be brought to a better condition than that of institutional charges for the term of their natural lives. One-fifth of the population of the State School at Rome lives outside it. No one knows yet how large is the proportion that can be so trained as to be fit to lead some form of extra-institutional existence. Training and trial have demonstrated that defectives, even the low grades, can accomplish far more than any one ten years ago would have believed that they could. Inmates had always been relied upon to help out the operations of the institutions, in the garden, on the farm, in making clothes, in general housekeeping, etc. But there is more of this kind of labor available than an institution can utilize, and so have sprung up the two great systems of *Parole* and of *Wage-earning Colonies,* the latter the creation of Dr. Charles Bernstein of Rome. These are still in their infancy and are far from having obtained unqualified endorsement from those long accustomed to the old ways of doing things. The objections raised to an expansion of these systems refer chiefly to girls and are that girls on parole or in colonies are not well supervised and that, during the child-bearing period, they are apt to be led astray and to increase the problem of mental deficiency by giving birth to defective children. In the farm colonies for boys it has been objected that the boys are dirty and poorly dressed, and that they are not educated sufficiently. Some of these objections are sound in so far as they emphasize the necessity of having the two systems planned with great care and carried out only when all reasonable safeguards are provided. But it is entirely practical to take such precautions, and when they are taken, the parole system and wage-earning colonies are the means of getting some of the institutional sediment into circulation again, thereby increasing the number of beds available for applicants who, without the colony and parole system, would be forever denied the advantage of institutional training. No community will provide accommodations sufficient to maintain, all their lives through, all the defectives in it who would benefit by institutional training. The outlay thereby entailed would paralyze the hand of any disbursing

body. But it is not too much to believe that some day or other intelligent communities will see the advantage of maintaining an adequate number of beds, which no community maintains now, if a reasonable proportion of inmates occupy them, not their lives through, but only long enough to obtain that training by virtue of which they can, under supervision, be returned partly self-supporting to the community. By thus creating an outlet for fixed institutions, the thousands of defectives always waiting in the community will be offered the advantage of training and supervision. The state will thereby assume the parental responsibility it owes them, which at present it fulfils for so few. A rough guess might put it that the state should supervise three defectives for every one it fully maintains.

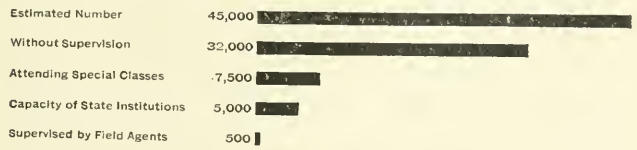
Those interested in the details of colony and parole organization and management are referred to the numerous articles and reports on these subjects. Here it is sufficient to say that one year's training in the institution seems the minimum stay before an inmate can be considered for either departure. Even then, the candidates, especially girls, should be selected with care and be prepared for the new step. In the special parole training class at Syracuse, the girls are given a course in all branches of domestic science. Their interest is thereby aroused and, further than that, they are the more highly prized by the families to which they are paroled. The families maintain them and pay them wages; so, although still under the state supervision, they cease to be of any material expense to it.

Since preparation for return to the community has become so important a function of all state institutions, the scholastic feature in the training given the children occupies a less important place than it once did. The object of education and training is to put the inmate as much on his own as it is possible for him to be, to remove him as far as possible from idleness and dependency, to prepare him for life as he is able to live it. The training, accordingly, must follow the lines of his special equipment as determined in the clinics and by subsequent observation. His chance to succeed is never along intellectual lines. For a defective to be able to compete in

the world of ideas would be a contradiction in terms. No system of education ever devised can bring that about.

To turn back to our diagram again, it requires no expert in hydraulics to perceive what happens when the channels of the Right Way are blocked up or the stops are not provided. The stream is forced back into the Wrong Way. The Wrong Way might indeed be called the Worst Way. For while it is not denied that the criminal courts, the homes, and even the prisons, all with their ever-extending probation systems, accomplish something for defectives, they are all in a valley too dark for the rays of the sun to touch it long. In that valley will never be found the absorption that must take place before our management of the problem of mental defect is on an intelligent basis. The Right Way has doubtless many wrong things about it, but these can be corrected with effort and time. Some one may say, for example, that the colony system is not sound because something unfortunate has happened in the case of some individual colonist. But such an objector might be asked what is happening to the thirty-two thousand defectives in the state of New York about whose lives we have no information at all.

Mental Defectives of School Age in New York State and Means Provided for Their Care, Education and Training



The above chart shows how little is being done at present even in the great state of New York. Approximately 70 per cent of defectives are under no supervision whatever; and yet New York is among the states that do most.

LAZINESS IN SCHOOL CHILDREN *

IRA S. WILE, M.D.
New York City

GLANCING through a report of a school committee, I was astonished to read that 538 children out of 8,496 children suffering from retardation (10.5 per cent of the elementary-school population of the city in question), were said to be retarded because of laziness. In other words, 6 1/3 per cent of the retardation in the schools of this particular city during the year 1910 was attributed to laziness. My feelings were somewhat assuaged in view of a statement in the same report that "long ago it was discovered that many pupils who were supposed to be naturally dull, inactive, or lazy were merely suffering from some physical defect which might have been removed or modified by the service of a competent physician or specialist".

What did the school authorities mean by lazy? What is laziness? Commonly as the term is employed, there is a dearth of material concerning its nature, its causes, its symptoms, and its treatment. I recognize that for some persons it is indeed an epithet, an expletive term to convey a sense of inferiority to an individual who fails to accomplish or to attempt to achieve what some one else desires or measures out for him. It is a stigma of uselessness—a verbal expression of the futility of living of the individual to whom it is applied.

In its ordinary usage, it is for the most part improperly applied. If to be lazy is to fail to live up to one's potentialities of accomplishment or activity, a large proportion of us might be so denominated. Too frequently it is employed to designate a temporary state of being wherein a lack of desire for effort obtains—a state to which the term inertness might be more accurately applied. By many the term is confused with idleness or indolence or slothfulness or sluggishness, or indeed mere inactivity. There is a much looseness in the use of many such common terms.

At the risk of verbal confusion, but for purposes of ac-

* Read before the Ward's Island Psychiatrical Society, October 26, 1921.

curacy, let us distinguish the essential differences among these synonyms. An idle person is one who does nothing useful, a lazy person is one who does nothing without great reluctance, while an indolent person is one who will do nothing or set about nothing. As Crabbe further differentiates them, the idler will not learn his lesson, but he is active in what pleases him; a lazy man has an aversion to physical action, but not always to mental action; while an indolent man fails in activity from a defect in both mind and body—he not only will not move, but he will not even think. These fine differences are rarely made; the term "lazy" is applied in the common dictionary sense of an indisposition to work and an aversion to action. The inert individual is not disposed to move, while the slothful never moves otherwise than slowly, and the lazy person moves with evident pain to himself.

Holding to these distinctions, it is evident that inactivity, or the inhibition of a stimulus to action, may result from a large variety of causes, such as modesty, timidity, fear, ignorance, anger, grief, and the like. Inertness may arise from any over-indulgence in bodily action. Slothfulness and sluggishness are types of inactivity that may be due to some variation of function superinduced by a physical disorder of a character sufficiently chronic to establish an habitual type of movement or a psychical depression. Laziness involves, to some extent, a dependence upon volition. There is an averseness to setting the muscular machinery into action, as if there were an extra burden to be moved.

Laziness, involving the aversion to physical action, varies greatly in origin, and in its more significant or chronic form may be determined by a fixed idea. In *Medicine and Surgery,* December, 1917, George Van Ness Dearborn discussed laziness in an editorial under the title *The Most Prevalent Disease.* He regards the chronic expression of physical laziness as a source of enjoyment, in pretense only or in reality—a state of being wherein the organism adjusts itself and finds charm in its idleness. In a humorous way, he calls the cause a parasite of the order of fixed ideas. The pathology he explains as "a bad habit fixed in all parts of the active system". Strangely, he remarks that it seldom develops in normal persons before the age of twenty.

Accepting for the time being the point of view that laziness is a habit arising from variable degrees of inhibition in the muscular-mental mechanisms, one may ask were the 538 children retarded because they were lazy, or were some of them mentally sluggish and unable to keep pace with their fellow pupils, and others inherently indolent from defects in mind and body? If laziness is most properly applied to the aversion to physical action, to what extent does physical inactivity carry with it the necessary corollary of mental inactivity? All of which again brings us back to our original questions: What is laziness and who is lazy?

It is generally conceded that life is dynamic. There is inherent in all protoplasm irritability with a tendency to reactive movement. In the development of species, activity of the mind and of the body is apparently a biologic necessity. In a sense, a constitutional objection to exertion predicates some physiologic or psychologic deviation from function. As Dearborn notes in *The Influence of Joy*,[1] "voluntary or personal bodily action involves mental activity, just as the latter, for modern psychology, in a sense depends upon bodily functioning; namely, on that of the neuro-muscular parts which by any one of eight or ten media express the psychic intentions impressed".

In the development of civilization, periods of activity have alternated with rest. Tremendous expenditures of energy have been followed by periods of inactivity. Primitive man was not essentially a worker. As Hall says, it is not dread of fatigue, but of the monotony of labor that makes primitive men hate labor. As phrased again by Hall: "There appears to be an instinct of revolt against uniformity imposed from without which robs life of variety and extinguishes the spirit of adventure and untrammeled freedom, and makes the savage hard to break to the harness of civilization". I do not mean to suggest that true laziness in modern times is a reversion to a primitive desire for freedom from restraints imposed from without. The untutored savage did, moreover, respond to conditions that threatened his personal or familial existence. His reluctance to move was overcome by the necessity of action for self-preservation, whether by reason of hunger,

1 Boston: Little, Brown, and Company, 1916.

danger, or threat of punishment by the herd. It is possible that much of what to-day is termed "laziness" might be overcome in the face of sufficiently personal stimuli that endangered existence.

It is normal for man to desire happiness, though this desire is frequently thwarted by a sense of inferiority that may convert honest self-expression into pernicious self-repression. Philosophers may talk of the joy of work and represent idleness as the mother of all evil, but there are those to whom work is a punishment, a chastisement, a flagellation, and an insuperable obstacle to contentment. Too frequently idleness is regarded as intrinsically laziness, whereas it may be but the reflection of an incompetence, lack of opportunity, or the non-development of an adequate incentive to personal effort.

In considering laziness as reported among the causes of truancy, we find data lacking to indicate to how great an extent what passes for laziness in reality is a compound of a dislike for the repressions of school, a desire to go to work, an apathy resultant upon ineffectiveness, or the urge of companions to promised adventure and excitement. True or essential laziness, as a habit based upon the inner nature of the child, I believe and shall try to indicate arises only in the indolent type of psychic constitutional inferiority. Psychic constitutional inferiority is well described by William Healy in *The Individual Delinquent*[1] as manifested in "chronic abnormal social and mental reactions to the ordinary conditions of life on the part of children who cannot be classified in any groups of the insanities, neuroses, or mental defectives". Children of this type are essentially egocentric. They are slothful, irritable, suggestible, and easily fatigued mentally. In addition to their weakness of will, they often show somatic stigmata of degeneracy. This represents a type of individual whose physical and mental activity is based upon an organic inferiority, but it certainly includes only a negligible percentage of those to whom educational authorities are so wont to apply the term "lazy".

It is obvious that the foregoing definition does not concern itself with causality, but is merely descriptive of a group the origin of whose peculiarities may be inherent in some neuro-

[1] Boston: Little, Brown, and Company, 1915.

musculo-glandular deficiency. One recognizes certain similarities in the weak will, suggestibility, irritability, and ready fatigability of this class, with its evidences of racial deterioration, and certain forms of exhaustion. As Crile remarks in *A Physical Interpretation of Shock, Exhaustion, and Restoration*[1]: "Exhaustion may be produced by want of food, drink, or oxygen; by exposure to cold or wet; by want of sleep; by a period of excessive muscular or mental work; by a prolonged emotional strain—worry or anxiety; by defense against chronic infection; and by a failure to eliminate waste products". Sufficient studies and investigations have not been made to determine in how far laziness may represent some exhaustive process that has undermined vitality and self-respect.

Groszmann points out in *The Exceptional Child*[2] that "laziness is often a symptom of anæmia or of neurasthenia or of vasomotor disturbances; or it may be caused by malnutrition, over-exertion at home, lack of sleep, or lack of ventilation in the child's chamber".

In an endeavor to focus attention upon the condition underlying what is so popularly miscalled "laziness", it appears to me that one must recognize a number of factors, any one of which may be responsible, although as a rule there is a combination of them active in causation. One must recognize intellectual weakness, emotional instability, and volitional indifference. These three factors may be developed, modified, or determined by impaired sensation, glandular dyscrasia, and nutritional inadequacy. There might be many multiplications of causal elements, but these six will suffice for the purpose of indicating my belief that most "laziness" is the symptomatic evidence of organic disease or a functional incapacity arising from physical or psychological causes that determine volitional decisions for inaction as a defense mechanism.

The manner in which this occurs will be further developed in connection with special instances of the dominance of one or the other factors. In fairness, in discussing intellectual weakness, all cases of actual defect should be disregarded. It is

[1] Oxford University Press, 1921.
[2] New York: Charles Scribner's Sons, 1917.

apparent that border-line states, dull-normal individuals, and children placed in grades beyond their intellectual capacity necessarily suffer in competition. It is understandable that after an absence due to illness, for example, it becomes impossible for them to grasp the lessons, and under conditions of easy fatigability, plus the sense of a useless struggle, they succumb to a method of inactivity that subjects them to the least strain. Hope of catching up becomes transformed into hopelessness, hopelessness into indifference, indifference into apathy—into accepted inactivity. The teacher, recognizing the lack of effort, upbraids the child for laziness. Thus the chain culminates in a desire to escape pain through accepting inferiority as an absolute rather than a relative characteristic.

In another type one may find an average capability in most school subjects, together with a peculiar disability in some single subject, as arithmetic or writing, which serves as a constant drag. The particular incapacity, with its repeated impact of failure upon the mind, develops a sense of the futility of effort which in turn may dominate other fields of mental activity. That neither of these types is intrinsically lazy or indisposed to action may be evident in their enjoyment of baseball, dancing, or games outside of school. The emotional reaction to the school and its environment clouds the picture of existent energy and falsely condemns the child to the opprobrium of laziness. These represent two types to whom might be applied Cowper's expression "indolent vacuity of thought".

The consideration of school records of retardation reveals a definite part that is played by faulty home conditions, incidental physical defects, frequent change of schools, difficulties with the English language, irregular attendance, and late entrance to school, as well as retarded mental development, delinquency, and the condition reported as "laziness". Terman mentions these various explanations of laggards in connection with the study of records of a Salt Lake City school. He found, however, that mental tests revealed an average mental retardation of three years. According to his findings,[1] "some 10 per cent of the school children of per-

[1] *The Intelligence of School Children.* Boston: Houghton Mifflin Company, 1919. p. 116.

fectly normal appearance have a grade of intelligence which is about halfway between that of the moron and of the average normal child". For these reasons he would place inherent mental weakness as the greatest conditioning factor for much that is regarded as "laziness".

If mental dullness be inherent, then there may be school failure despite adequate motivation, the awakening of interest, and a certain degree of application. Certainly, with existent school methods, it would be difficult to appeal to the desire for the enjoyment of success through increased efforts to overcome obstacles, when the inherent mental potentials are lacking.

The emotional phases of mental activity are exceedingly varied. It is obvious that emotional instabilities, so common in the adolescent period, provide a dangerous basis for emotional inactivity. The susceptibility to easily wounded feelings, the sharp reactions against ridicule and unreasoning censure offer unusual discouragements. The continuance of emotional revolt tends to lessen the sense of shame over failure to achieve conventional standards, and as the child becomes accustomed to rigid criticisms, there is a definite decrease in his self-respect. Once children become insensitive to the enjoyment of being respected by others and fail to seek and desire the good opinion of others, a vital emotion is destroyed or its place is taken by one of lower driving value.

The lack of balance between self-assertion and self-abasement assuredly is increased by the loss of motivation that arises from a sense of self-respect. If to this loss be added unashamedness, the weak-willed are greatly handicapped for sustained performance.

Mental hygiene would suggest the importance of weakening undesirable emotions through the stimulation of newer and larger interests, new friends, plays, places, and the stimulation of pleasurable emotions under normal direction; but such individualized attention is difficult to obtain in school systems. Strong emotions can be controlled only with the greatest effort to establish an intense libido with a correspondingly heightened affective urge.

Since with the emotional condition there are concomitant visceral relations that may present physical symptoms, the

emotional state becomes more physically fixed in its quantitative and qualitative character. It is important to bear in mind that physical reactions participate in the expression of emotions, and, in turn, may be reflective of them. Hence it is necessary to appreciate the psychical states whose influence passes into muscular, vasomotor, glandular, and neural reactions, as well as to understand the influence of visceral reactions in the causation of emotional conditions.

The part that an emotion plays in the creation of an ill will toward one's home or one's environment depends upon the quantitative character of the emotion as well as upon its quality. The sharpness of an emotional response helps to determine the degree of indifference to all impressions which are outweighed by more fundamental and aggressive egocentric reactions. It is recognized that physical sluggishness is frequently an evidence of mental disorder. This apathetic state may be manifested in a mere lack of interest in surroundings, in a decreased desire for application in industry, or in a diminished interest in familial welfare. Finally an actual depression may develop. Undeniably, emotional activity is accompanied by constant variations in health, but the period of duration of such activity is limited and is followed by more or less restoration to a plane of balance. The phenomenon of irregularities in quantity and quality of emotions characterizes the unstable period of adolescence. Prolonged alteration of emotions, however, and continued failure to react normally to stimuli would be more characteristic of a psychic constitutional inferiority. Hence, all emotions that tend to engender the ill will of individuals and lead to asocial or antisocial trends are particularly undesirable. Affective trends block the impulse to effort because of their weakness or their strength, depending upon the nature of the complexes to which they belong.

The mere objection to physical labor does not of itself constitute laziness. There are emotional reactions of a continuous character that, far from representing weakness of emotion, result in forms of activity not essentially laborious in character in so far as physical application is concerned. This is well represented in such fields of useful service as result from the emotional outpourings of artists, philosophers,

dreamers, and musicians, whose early life not infrequently reflects an indisposition to physical activity. A failure to dwell in the real, though conventional, living world and a tendency to establish a dream world for self-satisfaction may result in a mental preoccupation that precludes the direction of attention, save under the greatest urge, to the formalized work that has been established as of benefit to the community, but is not necessarily properly adapted to each and every individual. The phantasy may in itself be the cause of an inactivity that leads to the type of behavior so often resulting in the stigmatizing of children as dreamers, dawdlers, putterers, or slackers. Herein the emotional state merits more thorough investigation and sympathy rather than the driving, forcing, cajoling, or abusing that is utilized in an attempt to secure a desired effort.

Inactivity or sluggishness or laziness, even when it is accompanied by apparent good health, is not to be met by scolding, sarcasm, verbal abuse, or constant propulsion by arguments as to the worth of industry; the driven child is more likely to be seized by a distaste for work than is the child whose inspired or spontaneous interests impel him to activity. The rational course is to offer an external stimulus that will tend to create an inner urge. The personal impetus, self-derived, arises from the stimulation of such primitive instincts as curiosity, pugnacity, and the like. There is little question but that the undue stress placed upon precepts as to the value of work is counteracted by the obvious acclaim which the community so frequently yields to those who do the least physical labor. Children often are aware of this distinction and desire to ally themselves with the honored group, who labor least, rather than with the group whose apparently more arduous efforts are attended with comparatively less community recognition.

Normal children in abundant health and vigor possess tremendous reservoirs of energy for which they seek outlet. A damming back of activity in children of this type results in an unnatural sluggishness, inertness, or apathy that at once calls for medical investigations. Such sluggishness or apathy often represents the onset of some one of a number of contagious diseases whose first symptoms are expressed in altered

behavior. The persistence, however, of these same symptoms too frequently results merely in an indifferent and acquiescent recognition of their unfortunate character, and the term "laziness" is accepted as an adequate explanation of them. The use of this term under such circumstances is a verbal denomination of a condition that is not understood, and indicates merely a failure to comprehend the nature and trends of the child's mind.

Certainly habitual apathy or constant indifference calls for investigation. One may say that the remedy lies in the establishment of habits of industry. This is of course true, but it is more difficult to achieve than it sounds. It is too often forgotten that the energy outlet must be into channels that possess some real significance to and for the child. The conventional studies, manual work, or occupational direction that our schools provide may be just as ineffective as the limited opportunities afforded in the home, in so far as any particular child is concerned. There has been too much domination by the adult point of view and a corresponding failure to interpret life's activities in terms of children's needs and natures. There is greater advantage in the doing of anything than in the doing of nothing. The habit of activity is paramount in the development of personality, and from the educational point of view the medium through which it is attained is relatively inconsequential. The superior assumptions of adults all too frequently run counter to the natural impulses of childhood. A child's education in activity is not to be regarded as purely disciplinary, a mere effort to keep him busy. His individuality merits recognition and his specific instinctive or acquired interests are not to be constantly thwarted, regarded as puerile, and, therefore, foolish or wholly undesirable and ineffective. The danger of the more or less constant blocking of normal impulses to energetic expression is not fully appreciated. Inherent interests demand cultivation for the purpose of encouraging the continued volitional direction of conduct along useful lines for the development of the personality in its relation to the herd.

Volitional indifference or volitional disinclination results in a partial paralysis of the will for definite types of action. Even delusional disturbances of volition may cause such abnormal behavior as is termed "laziness".

One recognizes that the will "is the whole mind in action". It is the doing phase of ideation and motivation. The difficulty of interpreting actions is due to the unpredictability of the associations and emotions aroused by any particular stimulation. Volitional response for activity is motivated by clusters of ideas and ideals with their emotional fringes, and these are particularized for each individual. One can recognize the difference between volitional tendencies that result from similar stimuli under conditions that are varied only by the presence of toothache at one time and its absence at another. The most important influence in voluntary action is the entire life history of the individual, with all his developing trends and attitudes. This in itself is a measure of the difficulty of discussing the problem of volitional indifference.

The idiomotor phase of volition, admittedly, closely correlates with emotional states, particularly after the evolution of sentiments. The fixity of reactions produces a reasonable degree of dependability in action. But conflicts of ideas may introduce an element of uncertainty that leads to a distinct unreliability, because the dominating associations of the time will in all probability determine which consequences are personally the most satisfying and therefore to be selected. Regardless of the complete integrations, active effort may be inhibited by powerful particularized groups of associations in the foreconscious mind that have taken on inhibiting feeling-tones by reason of educational experiences that thwart the emergence of helpful unconscious instinctive action.

In the process of socialization of individualistic tendencies, inhibitions are of major importance. A prominent basis of inhibition is fear. The interpretation of what is to be feared naturally depends upon a life experience, with all its associated memories and inherited trends. It is possible, therefore, to recognize the highly suggestible individual whose will accepts almost every suggestion as part of itself, and therefore as compelling; and on the other hand to understand the mind that is so distraught with obstructive conflicts as to be incapable of decision or completely unable to act. Thus one frequently recognizes the child who would like to, but cannot; who says he is trying, but doesn't seem to be able to get anything done. Voluntary action is the result of two forces—

one tending toward expression and the other tending toward inhibition.

It has been stated that a voluntary act requires (1) an idea of the thing to be attained, (2) a desire for its attainment, (3) a belief in the possibilities of its realization, (4) a memory of similar action in the past, (5) and a sense of comfort or relief with the accompanying strain toward the establishment of the desired end. Accepting these for the time being, one perceives the manifold possibilities of interference with a voluntary act directed toward activity. Any one of these five conditioning elements may be lacking. How frequently does a child say: "What's the use?" "What good will it do me?" "I don't see where it's going to help me." "I don't think it's worth while." How frequently does the child remember its previous failure in effort directed toward the same direction! How often is there realization of an inability to bring things to pass! Around each of these is a cluster of associations involving emotional reactions that are of a powerful, obstructive, or impelling character. This is merely another way of stating the need of cognitive, affective, and conative elements in the release of energy.

Patently there is an implied judgment in volitional action unless one accepts a psychological theory that fetters the freedom of the will. If all action is compounded merely of impulses arising through the sympathetic and parasympathetic systems, the problem of laziness becomes almost insuperable. If laziness is construed as a voluntary action, it is based upon a weakness in judgment as measured in terms of conventional opinion. Thus there is evident a clash between the egocentric and the herd instincts. If there be a relative muscular inactivity, despite a moderate degree of desire, the volition may be partially predetermined by inhibitory emotional complexes, fear, or defective nutrition. Desire in itself does not guarantee activity; for example, a sense of hopelessness may inhibit all action, as may grief, anger, and similar emotional states. If one interprets desire as the consciousness of an emotional state, then will is determined by emotions. This is, however, contradicted by the frequent willingness to function against the temporary emotional urge. Conscious maladjustments, as well as those

born of subconscious trends, are potent elements in prejudicing judgments when experience is limited. Loves, hatreds, and the like that develop from unpleasant home settings influence and condition willingness to act.

The habit of inactivity tends to decrease potential power and dries up the wellsprings of human action. Repeated action itself tends to diminish fatigability of the mind and body, whereas disuse of bodily functions increases fatigability.

With our present-day ethical concepts, we appreciate the importance of a will self-controlled, self-directed, and strongly motivated by the ideas of social usefulness. Efforts to counteract volitional indifference must carry with them the idea of making an agreeable impress upon the individual for the furtherance of his individual expression in terms of personal and social advantage.

One readily grasps how repeated failure may condition habitual inactivity. The bursting asunder of the volitional restraints that lead to inactivity depends upon increasing and deepening the number of association patterns of success with their emotional tracery, particularly during childhood, the period of greatest plasticity. Failure to accomplish this results in the persistence of the puerile attitude and the continuance of the fixed negative trends of this period until such time as more effective motivation may overcome the inhibitions.

By some, laziness might be interpreted as an exhibition of a return to infantilism. It is not Narcissism, nor does it appear to be a detachment of a pleasurable state as a determined end. Neither does it involve the idea of a vegetative existence as the end and aim of life.

Postulating intellectual weakness, emotional instability, and volitional indifference as the primary conditioning factors of what too frequently is termed "laziness", one may suggest that there are involved in all of these certain substrata of a determining character. Among these I would enumerate three as of especial importance—imperfect sensation, nutritional inadequacy, and glandular dysfunction.

From the medical point of view, it suffices merely to point out the psychological consequences of imperfect sensation. It is immaterial whether the underlying causes are central,

mediate, or peripheral. Whatever interferes with the fullest development of sensation must influence the ideational and emotional life, and thus, by hampering cognition and affect, directly influence conduct as manifested through volitional action. Without going into detail, I may call attention to the interferences with the normal development of personality that result from uncorrected myopia or deafness. It requires no prolonged discussion to emphasize the tendencies to inactivity that may result from interferences with kinæsthetic function. The limitations of muscular sensation resultant upon injuries, defective structure, muscular unbalance, and a recognition of their consequences are partially responsible for the increased interest in vocational rehabilitation.

Even moderate disabilities of speech not conditioned by psychic disorders may result in inhibitions of serious moment. A slight degree of hydrocephalus, a birth palsy, and countless other disease states that interfere with the freedom of the channels of sensation have powerful effects in developing attitudes and trends that create a volitional indifference based upon intellectual weakness or emotional instability.

The term "nutritional inadequacy" I am using in a broad sense. It includes fatigue states, conditions of bodily suboxidation, vitamine deficiencies, the results of infections, and parasitic invasions. One recognizes the preventable fatigue states, partially delusional in character, that are born of a too keen consciousness of defects that literally make their possessors tired. Somewhat similar are states of inactivity superinduced by the constant direction that rest is necessary and the acceptance of the inactivity as a protective mechanism.

Under the head of suboxidation I am including, for example, a variety of conditions, some of which, technically, may be said to be classified improperly. Herein I am including malnutrition, whether due to undereating, overeating, or to such constitutional diseases as diabetes mellitus and various forms of chronic intoxications, either by foods or other deleterious substances.

The vitamine deficiencies are certainly potent factors in scurvy, pellagra, rachitic manifestations, and other conditions in which activity is distinctly limited.

The infections embrace all the communicable diseases, but

for the most part, in the more common types, their primary effects are based upon their sequelæ, especially those involving the nervous system, the heart, and the kidneys. Tuberculosis and syphilis are of great significance in this category, with far greater stress upon the former, because of its more widespread nature during the juvenile period of life.

Under the head of parasitism, uncineriasis and vermes, in general, form the essential conditioning elements for reduced activity.

The subject of endocrinology, with its high degree of indefiniteness at the present time, merits consideration in view of the undoubtedly important part that the ductless glands play in the development of the body, anatomically, physiologically, and psychologically. The tremendous influence exercised during adolescence by glandular readjustments cannot be rejected. The effect upon personality that arises from dysfunction of the thyroid and pituitary glands deserves especial thought in connection with sluggishness and inactivity as well as in conditions of hyper-excitability. The importance of the secretions of the adrenal glands and of the gonads makes it necessary that they be included among the factors that enter into the conduct of the allegedly lazy.

In my estimation it is wrong to castigate individuals for truancy or for being laggards, and to denounce them as hopelessly lazy, without a thorough investigation into the underlying reasons, which may be found in organic diseases or functional incapacity. There is too great freedom in the use of the terms lazy, loafer, sloucher, slacker, truant, dawdler, and the like as words of finality. These terms in themselves, as characterizations, are to be regarded as indicative of symptoms or manifestations of disorder. As such they demand and deserve a thorough physical, psychological, educational, and social study, with a utilization of all the methods that thus far have proven themselves of value. When, and only when, no other definite etiology for the conduct disorder can be determined, one is justified in regarding the laziness as basically an evidence of psychic constitutional inferiority.

CROSSBREEDING OF IDEAS AS A FACTOR IN INVENTION

THOMAS H. HAINES, M.D.

Field Consultant, The National Committee for Mental Hygiene; Director, Arizona Mental Deficiency Survey

THE great question in psychology to-day is that of organization. This is the question equally in our investigations of attention, memory, imagination, perception, and conception. How do the vague things in consciousness become clarified by being split up into parts, and how is experience, with its manifold differentiations, after all, agglutinated and organized as one experience? In a word, how does it come about that experience covers and fills in gaps in itself?

A large amount of mental organization comes through reproducing the copy that one gets from one's social environment. Social heredity is a powerful factor in the organization of the mind. Of course the organization has to come to the mind, as to all organic beings, from within. Imitation is an instinct that sets the psycho-physical being into action and brings to it a wealth of mental organization without conscious seeking. But with all the recent exploitation of imitation, we see that it can constitute the explanation of the *similarities of organization* alone in the ontogenetic development of beings of a given order. For the variations by which real progress comes to human society, we must clearly have some other explanation. There are many reasons for believing that mental variation is more significant in human evolution and development than is physical variation in either the plant or the animal kingdom. And since so little is known about the method of mental variation, while relatively so much is being learned of plant and animal phylogenetic variation, the question arises: Can we not learn some valuable truths in the field of psychology by applying the method of the biologist in our study of mental variations?

For the production of valuable strains of plants and animals, breeders in both lines, since the days when Bakewell produced his striking results in sheep and cattle, have very

generally practiced the selection of individuals that best realize their *ideals* and the breeding of these together. If this procedure be continued for many generations, the same *ideal* being kept constantly in mind, a marked alteration of type is produced. In both lines hybridization has also been used very extensively to secure a combination of desirable qualities not found in the same species or variety. This crossing of varieties has been used even more extensively in recent times for the production of new varieties, especially in plants. By this method have been produced the seedless orange, the seedless plum, the hardy English walnut, the hardy sweet orange, and many other very remarkable results. Studies in heredity show a comparatively close approximation to Mendel's law. It can be quite definitely foretold in what proportions the two sets of factors crossed will present themselves in the first and in each successive generation. Nilsson has further shown that there are in any given so-called variety a large number of varieties which, if carefully selected out and bred in complete isolation each from the others, will breed remarkably true; and that they even go somewhat further apart. For the practical purposes, therefore, for which his station at Svalof was founded, this is found to be a much more expeditious method of getting better varieties fixed than the older procedure of selecting the best of a given variety for many generations. But herein Nilsson is doing with plants as nearly as possible what Bakewell did with animals. Bakewell saw his ideal and selected constantly the best approximations to it. Nilsson, with his experienced eye, can see the characteristics standing apart in his peas, let us say, and he simply selects individual plants showing the pure type and finds that they breed true very generally. But with all the care of either, it is found that there is a tendency toward the comparatively rare production of sports, and that when these come, they come suddenly. These are the *mutants* of Hugo DeVries. Now—though this is by no means proved—it seems that crossbreeding has the effect of producing a decided unsettling of the organization of the hereditary elements in both the parent cells, and so is especially fruitful in variations.

So it is, I believe, in the history of science. The impact of ideas upon one another, differing, but not too widely, is pro-

ductive of fruitful variations in thought. They jar and jostle one another, and thus bring out in thought what we may aptly compare to DeVries' mutants—new mental organizations, inventions, or theories. I wish to make it very clear that I do not mean by this word *organization* simply the synthesis or agglutination of the elements of experience—the aggregation of sensory elements into percepts and concepts. Even writers on logic are many of them now very emphatic in their statements that there are no thought processes which are purely analytic or purely synthetic. Bosanquet uses the illustration of thinking out the mechanism of a watch. When getting hold of the parts, one is always seeing them in their relations as parts of the whole, and the meaning of the whole can be grasped only by seeing the various parts working together.[1] It is certainly a matter of common agreement among psychologists that analysis and synthesis proceed together and that both of them are necessarily implicated in every case of thought consciousness. It is only in a circumscribed, and therefore falsified, introspection that we seem to find thought proceeding purely analytically, or purely synthetically. Thinking may be compared to the finding of the path in a strange wood; and this we see as both the learning of specific landmarks and the securing of a comprehensive visual and kinæsthetic plan of the district. Knowledge of the topography of the region becomes enriched by a constant addition of detail of descriptive information, an essential part of the describability of which is always found to consist of its relationships or its organization.

A simple concrete case will make this even more apparent. There is a common parlor puzzle game in which two strings are tied around the wrists of two persons, the strings themselves being crossed. Each person has his hands tied together by a string, and this string is inside the circle of arms, body, and string of the other person. The problem for the persons in question is to get themselves apart without breaking the strings or slipping the tied strings over their hands. It is a simple mechanical puzzle. The solution consists in taking the middle of either string through either of the tied loops

[1] Bosanquet's *Logic*, I. p. 102.

of the other string and around the hand beyond. It is a very simple succession of positions, and when once done and seen in its entirety, it can be easily grasped in a single visual image enriched with kinæsthetic data. The visual image here is the plan or scheme that hangs the data together. What it is, is shown by the contrast between this state of mind, when we have done it and know how we did it, and that state, when we had done it by accident and could not find out how we did it. In this case of accidental performance, we lack both synthetic and analytic factors of the more complete experience, but the striking lack is of what we call a *plan of the procedure.*

When Agassiz was at work in Paris on a particularly baffling fragment of fossil fish, he dreamed one night that he saw the completed form. On waking, he could not get it. Further, on going next day to the specimen in the Jardin des Plantes, he could not get it. Next night he had the same vision, but it eluded his waking consciousness. The third night he determined to catch it, and so laid pencil and paper on a table beside his bed. The vision came again and, still half dreaming, he sketched it in the dark. In the light of the morning he was much surprised at many details of the rough sketch. He thought they could not possibly be true of the specimen. But on repairing to the specimen and chiseling away the rock in places where the sketch showed parts he had not seen, he actually found the parts as in his dream sketch. This is related here to show again how the *prefiguring of the imagination* brings in data and builds the plan upon which they are organized.

The same sort of prefiguring schematizing was at work when Copernicus thought out his heliocentric system, Newton his gravitation hypothesis, Schwann his cell theory, and Darwin his origin of species. These theories are typical of all the advances in science. They are cases of fruitful variations in human thinking. Our thesis is that they and many other such variations are the products of a shaking up of the schema or theories possessing the mind by the impact of other ideas upon them in some such manner as are the hereditary elements in the ovum and sperm cell in the processes of fertilization succeeding the moment of impact of one upon the other. In the limits here prescribed it will be possible to in-

stance only a few cases of such *variations in thinking caused by the impact of ideas,* and then to dwell for a few moments on the mechanism of variation in mental development.

In his lucid account of his own mental history, we find Charles Darwin, the rather careless son of an English physician, discovering a little interest in geology from a few field excursions with Sedgwick, getting a berth on the *Beagle,* and taking with him Lyell's then new *Principles of Geology,* with the warning from Henslow not to adopt its theory. With the uniformitarian theory of Lyell in his mind, Darwin was greatly impressed (1) by discovering in the Pampean formation great fossil animals with armor like that on armadillos; (2) by the manner in which closely allied animals are found to replace one another as one proceeds southwards over the continent; and (3) by the South American character of most of the productions of the Galapagos Archipelago, and more especially by the manner in which they differ slightly on each island of the group, none of the islands appearing to be very ancient in a geological sense.[1] These facts confronting Lyell's theory in his mind, there remained for him no alternative interpretation of the facts but a theory of the gradual modification of the species. And as his mind dwelt upon the great biological problem, there seemed to him every reason to expect an explanation of this gradual modification of existing forms through the selection of variations. This turned him to a careful study of selection by breeders of animals and plants. He naïvely remarked his surprise in later years when he read the lists of books and periodicals that he abstracted in a few years after returning to England.

Then comes the most remarkable case of crossbreeding in Darwin's mental history. He says: "In October 1838, that is fifteen months after I had begun my systematic inquiry, I happened to read for amusement Malthus *On Population,* and being well prepared to appreciate the struggle for existence which everywhere goes on from long-continued observation of the habits of animals and plants, it at once struck me that under these circumstances favorable variations would tend to be preserved, and unfavorable ones to be destroyed.

[1] *Life and Letters of Charles Darwin.* By Francis Darwin. New York: D. Appleton and Company, 1888. Vol. I, p. 67.

The result of this would be the formation of a new species. Here then I had at last got a theory by which to work."[1]

In the same way when, in 1774, Priestley's discovery of "dephlogisticated air" was announced in Paris, it came to the mind of Lavoisier as at once a shock and a reorganizer of his theories. He had carefully worked over the results of Black, Cavendish, and Priestley, confirming their facts, but skeptical of their theories. So his mind was charged with a mass of ideas ready for fructification or organization. And Priestley's discovery was the necessary fertilizing principle. His theory, which conceived of the dephlogisticated air as the "universal acidifying principle" and named it oxygen, was to chemistry very much what Copernicus' heliocentric theory had been to astronomy.

Again, in 1597 we find William Harvey, a Cambridge graduate, going to Padua to get a medical education. Padua, although largely under the domination of the antiquated anatomical notions of Galen, had had, however, in her line of teachers the great medical discoverers. Sylvius had discovered the valves of the veins, and Fabricius, who was teaching in Harvey's day, had further described them. Vesalius had discovered that the septum between the right and left ventricles of the heart was complete. And Servetus had made out the pulmonary or lesser circulation in that he proved the passage of the blood from the pulmonary artery to the pulmonary vein. At Padua clearly was the fountainhead of medical knowledge of that time. But it was still taught that veins and arteries had the same function, that the sluggish movement of the blood was caused by the heart *sucking* it back. The impact of the facts above related as Paduan discoveries, however, upon the mind of the young Britisher immediately set him upon an investigation of the effect of tying ligatures upon the veins and arteries of dogs. The facts discovered by Sylvius, Vesalius, Servetus, and Fabricius fructified into a theory in his mind, and the investigations upon which the theory set him confirmed the theory.

In 1836, we find Louis Agassiz, the brilliant young classifier of fossil fishes, expressing doubt as to the probability of the

[1] *Life and Letters of Charles Darwin*, p. 68.

theory of the action of Alpine glaciers as an explanation of the erratic boulders even on the slopes of the Jura. Whereupon his friend Charpentier, the author of the theory, invited him to come to his home in the Rhone valley at Bex and see the facts for himself. That summer Agassiz saw glaciers in action at Bex and at Chamonix, and was not only satisfied with Charpentier's theory, but thought the glacier action was responsible for much wider geological phenomena than it had been so far used to explain. In the summer of 1837, he unfolded a glacial theory of cosmic import in his presidential address before the Helvetic Association at Neuchatel. Charpentier's theory fertilized the mind of the paleontologist.

In 1844, we find Pasteur, a boy of twenty-two, walking in the gardens of the Luxembourg one Sunday afternoon, pouring into the ears of his close friend, Chappuis, the wonderful problem of the paratartrate or racemate which had been accidentally made at a tartrate factory at Thann in 1820, and which no one had since succeeded in making. The problem was this: Mitscherlich, a Berlin chemist, had found that while solutions of tartrates rotated the plane of polarized light to the right, this paratartrate or racemate was inactive toward polarized light, though they both seemed of exactly the same molecular and crystalline structure. These similarities, Pasteur felt, could not be as they seemed, with such a striking difference in the behavior of the solutions toward polarized light. This sharpened his observation so that one day he discovered, among the crystals of the inactive solution of the paratartrate, two kinds of faces. Upon carefully separating these and dissolving them separately, he found that one solution rotated the plane of polarized light to the right, as did the true tartrate, and the other solution rotated the plane of such light to the left. This he called lævo-tartaric acid. The two mixed together again produced an inactive solution like the original paratartrate.

In these instances—and many others that will have occurred to every one—it is apparent that the fertilizing idea does not always come from another mind. The origin of dialectic is social. The mind of a man sharpeneth that of his friend as iron sharpeneth iron! But nothing is more patent in the history of mental development than that the dialectic process

takes place in some measure in the individual mind. As Dewey puts it: "No process is more recurrent in history than the transfer of operations first carried on between different persons into the arena of the individual's own consciousness. The person becomes a miniature social assemblage."[1] Granting, then, that the impinging idea may come either from another mind by speech or writing, or from sensory experience, or may be reproduced by memory processes at the time of impact, the fact of impact stands out as the significant factor in mental creation. It is the *"shocked" consciousness* that is *productive of mental variations,* as it is the hybridizing in animal and plant breeding that brings out the greatest numbers of variations.

This is what Professor Royce means by "the social contrast effect", by "putting the individual on his mettle", and by calling attention to the "restlessness" of the inventive age and of the inventive individual.[2] It is an upsetting of present mental equilibrium that is the necessary preliminary, and that also constitutes the demand for an adjustment on a higher level.

The psychology of this shock effect of impinging ideas and the resulting mental variations can be best comprehended under the concept of *problem consciousness.* Granting that the shock produces the problem consciousness, we may very briefly inquire what it is and how it works. It may be defined as an awareness of something that is felt to be a possible organization of ideas and functions which the subject is as yet unable to bring clearly into experience—or, as we commonly say it, he is unable to realize it. Its structure is as the dream or the ideal. It is tantalizingly real as mental content, and yet it is unrealizable for the time being, in the sense that it *cannot be made to function in experience.* In this sense it is a definition of a *want,* and is in so far typified by the forgotten name that one wants to recollect. One knows what

1 Dewey, John. *Some Stages of Logical Thought. Philosophical Review,* Vol. 9, September, 1900. p. 465.

2 Royce, Joseph. *The Psychology of Invention. Psychological Review,* Vol. 5, pp. 113-44, March, 1898. See also Royce's *Outlines of Psychology,* Chapter 13: *The Conditions of Mental Initiative.* New York: The Macmillan Company, 1903.

one wants, but cannot get it. Both are known in an incomplete sense. The awareness of the incompleteness is itself an emotive force impelling toward realization of the completion of the experience. In other words, the *problem is a restlessness* amongst the elements of experience, and this restlessness is more or less definitely tending toward a given new equilibrium, the suggested solution. The impact of ideas produces tentative suggestions of new relationships, and begets, as a part of the same conscious process, impulsions and actions for the realization of these relationships in experience.

Thus the *felt problem,* being at once problem and suggestion of its own solution, is itself the motive to the more efficient organization of experience. The suggested solution is the ideal which lures and drives to action and constantly guides the action to bring about its realization. In this *problem* state of mind one thus sees the arena whereon arise the conflicts of experience, and whereon they are fought out and resolved, if ever they are resolved. It is the very region where experience is actually made. Of course, this is the field of suggestion. When a conflict is on, the individual is ready for the suggestion from his fellow or from any other aspect of his own experience that may help him by analogy to a solution of his difficulty. But there are constantly arising in the experience of the truly human individual situations that are quite new—that have not been solved. For the solution of these social suggestion is quite unavailing, and the individual wishes to be alone.

A most important guage of mental ability lies in this problem consciousness. For the capacity for the appreciation of the problem is chiefly a matter of the grasping power or scope of the attention. It is getting differences to confront one another. The greater the scope of attention, the larger the problem that can be comprehended, and the better the guidance of the action making for its solution. But scope of attention does not cover the individual differences that we find in this field of inventiveness. There is an emotive element, and with it a further rational element which is more than is usually connoted by scope of attention. It may be called a *demand for the integrity of experience.* It is one thing to see a problem. It is another to demand its solution.

I do not say that these are entirely separable, and that we find an appreciation of a problem entirely divorced from any demand whatsoever for its solution. But it is a fact that the demand for solution may be very weak in one mind and strong in another, while both appreciate the problem element equally. This demand for the integrity of experience is what makes men valuable to society. The man who has this most is he who is most productive of actual inventions in both science and art. It is capacity to use most efficiently the situations that life creates by means of impinging ideas.

THE PERSONAL PSYCHIATRIC HISTORY*

History Taken from the Patient by the Social Worker Preliminary to the Neuropsychiatric Examination— A Basis for a Complete Social Psychiatric Case History

LILA KLINE

MENTAL disease, unlike many forms of physical disease, "is not a something that comes from without, attacks and seizes on the patient, like, for example, a pathogenic micro-organism, but is rather to be considered as a type of reaction of the individual to certain inimical conditions".[1] The social psychiatric history developed when the psychiatrist came to realize that in order to ascertain these inimical conditions, he must have a knowledge of the patient's milieu, of the conditions that have surrounded him, of the special social forces that have been at work upon him, of the methods he has found and used in meeting these pressures, and the success or failure of these methods. A history sufficient to enable the physician to make a diagnosis can usually be readily obtained by the physician himself, but when the aim of the physician is more than the mere classification of his patient—when his interests are dynamic rather than static and he desires to understand how the patient has come to react in a particular way in order that he may, if possible, assist the patient in unraveling the strands of his life that have become entangled and meshed—then a history not only becomes time-consuming, but leads into fields somewhat apart from the ordinary course of medicine, in which the physician, therefore, cannot be expected to be expert in his collection of data. With the development of a more dynamic psychiatry, the need of social information in regard to the patient has increased, and it has seemed necessary to develop a method by which it could be

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1 White, W. A. *Outlines of Psychiatry.* Washington and New York: Nervous and Mental Disease Publishing Company, 1921.

obtained in such a way as to safeguard reliability of information, on the one hand, and the time of the physician on the other. As the first step in such an experiment, the psychiatrists have turned to the social worker to see if, perchance, she, with her degree of expertness in the social field, may not be the source of the information they desire. With special training to fit her for the task, the psychiatric social worker has recently been attempting to procure the social data from the patient's environment in order to give the physician a "conception of the individual before he became afflicted".[1]

Another step was taken in the development of medical histories when a social psychiatric case history was created to supply the joint demands of the medical and the social fields. This history includes both the personal history (the history taken from the patient prior to his examination by the physician) and the social history (the history from outside sources). Because of the results achieved in the field of mental hygiene, the need of psychiatric service has far exceeded the number of psychiatrists trained to meet the demand; and to add to the complexity of the situation, the ever-increasing development of psychiatry in its social relationships is forcing the physician to realize ever more keenly the necessity of long interviews with each patient. At the same time, in the social field, the need for a complete investigation as a foundation upon which to base social treatment—that is, the adjustment of family, financial, industrial, recreational, and other situations in order that the advice of the physician may have a prospect of being carried out and the maximum good to the patient be obtained—has become obvious. The social psychiatric case history is an attempt to meet both situations at once by having the social worker conduct an unhurried interview with the patient prior to his psychiatric examination in order to secure as much information as possible for the use of the psychiatrist and, at the same time, the initial data upon which to build up the social case. The supplementary investigation of outside sources is necessary in both instances to make the history complete.

It is the purpose of this paper to show the development of

[1] White, W. A. *Outlines of Psychiatry.*

this method as an experimental plan in one clinic, comparing it briefly with methods adopted elsewhere, and to present data both favorable and unfavorable as to the advisability of continuing it. Special emphasis will be laid upon the preliminary neuropsychiatric history obtained from the ex-service man suffering from a mental and nervous disorder that is yet in a border-line stage. To the lay person, this type of individual seems merely irritable, suspicious, depressed, or stupid, or with other traits that act as barriers to normal social intercourse. To the social worker these symptoms are signposts that she must follow carefully if she wishes to understand the individual and his social difficulties.

The work of psychiatric history taking was started on a small scale in the medical clinic of District No. 10 of the United States Public Health Service in Minneapolis, Minnesota, by a graduate of the Smith College Training School for Social Work. At the request of the United States Public Health Service, the National Headquarters of the American Red Cross asked that a survey of the psychiatric needs of the Public Health Service in District No. 10 be made with a view to instituting, if it seemed desirable, a psychiatric social service. According to figures published by Dr. Thomas W. Salmon, 27 per cent, or almost one-third, of all ex-service men hospitalized by the United States Public Health Service at the present time are suffering from mental and nervous diseases.[1] The survey disclosed that, with only one psychiatrist working in the clinic three hours a day and with the chief neuropsychiatrist having only several hours a week to devote to the examination of the ex-service men of North and South Dakota, Montana, and Minnesota, the physician did not have as much time as he needed for the examination of each man, and no time to discover social maladjustments and to straighten out compensation tangles. In consequence, two trained psychiatric social workers were employed by the Northern Division of the American Red Cross. One was placed in the medical clinic to obtain information from the men before the psychiatric examination: to secure a detailed account of the patient's life and present difficulty in order to

1 Statistics published in the *American Legion Weekly*, Vol. 3, pp. 5-6, January, 1921.

prepare the way for a strictly medical examination by the psychiatrist; to obtain such information of the patient's present situation as would be helpful to the social worker who must assist him; to obtain a detailed account of the military history in order to ascertain what relation the disability bore to service, to give the Bureau of War Risk Insurance a more definite idea of what would be a fair rating for compensation; and, finally, to acquaint the patient with the methods of the government bureaus and agencies. The other worker was placed in the office of the Northern Division to handle the vast amount of correspondence connected with the psychiatric and compensation problems of the out-of-town men.[1]

An office for the Red Cross psychiatric social worker was established in the medical clinic of the district office in October, 1921. The routine plan for the neuropsychiatric history is that every ex-service man who is sent to the neuropsychiatrist for an examination—whether referred by a medical consultant or directly from Washington by the Chief Medical Advisor—comes to the office of the social worker immediately after his physical examination. He comes with the understanding that the interview will consume some time and is a part of his examination by the specialist. If an interview is impossible at the moment, the social worker makes a later appointment with him. The social worker's inner office is similar to the doctor's office, and is free from intrusion. The interview is made easier by the willingness of the patient, due to the fact that he considers it a part of his complete examination, a necessary step in the process of securing compensation. If a patient shows any unwillingness, it is possible in a few words to explain to him that such a history is necessary in order that the doctor may be able to understand how his "nervousness" differs from the next man's. This explanation is adapted to the patient's apparent intellectual grasp.

The outlines used in taking histories in various clinics are more similar in form than the methods of procedure adopted by these same clinics would indicate, the difference being prin-

[1] For an account of this work, see *Case Correspondence: A Method of Psychiatric Social Work*, by Elizabeth C. Hayes, pp. 125-155 of this number of MENTAL HYGIENE.

cipally one of thoroughness in filling in the details under the chief topics. The thoroughness depends largely upon the amount of time allowed for the investigation of the patient's background. There is, even, a very slight difference between the outline for the social history and that for the personal history, the one being rather a verification of the other. Each history attempts to cover in more or less detail the family history, the personal history—including prenatal conditions, the early health and habits of the patient, his schooling, occupational history, and development of traits and habits—the marital history, the home situation, the financial status, and the patient's appearance and attitude during the interview. The form of history used by the Red Cross and that used by the United States Public Health Service vary somewhat in that the latter usually adds two important headings, *Military History* and *History After Discharge,* with a special paragraph under *Present Condition* relating to the patient's treatment by the government in the matter of compensation, medical treatment, and Federal Board training, and a statement of the patient's opinion as to the justice of the treatment accorded him.[1] This was the form of history adopted by the psychiatric clinic of District No. 10, United States Public Health Service, October, 1921, when the two new psychiatric social workers prepared a tentative outline which was revised somewhat by Dr. J. C. Michael, Chief of the Psychiatric Service, and Mrs. John Ward Young, District Supervisor in Charge of Psychiatric Social Work for the Red Cross. This form, with modifications to suit individual needs, is based on a survey of the outlines used by the following clinics: Atlantic Division, Red Cross; New England Division, Red Cross; Southwestern Division, Red Cross; Public Health Service clinics; Boston Psychiatric Hospital; and the United States Public Health Service hospitals at Philadelphia and West Roxbury, Massachusetts. The workers were also guided by the outline in the appendix of White's *Outlines of Psychiatry.*[2]

[1] The form of outline adopted by District No. 10, United States Public Health Service, Minneapolis, is given in detail in Appendix I, which has been omitted here for lack of space. Both it and Appendix II will, however, be issued with the reprints of this article.

[2] See note 1, p. 93.

Despite the similarity of the topics that guide the interviewer in securing data for the psychiatric social history, the difference in content of the resulting histories would be rather surprising if one did not stop to consider the range in training of the persons who take the histories, the varying conditions under which facts are secured, and the discrepancy in the time allowed for each interview. For instance, topics upon which two hours are spent in some clinics are covered in fifteen in others. In these latter the workers are usually advised by the psychiatrist or chief social worker merely to touch on the "present complaint" with a perfunctory question, "How are you to-day?" and then to pass rapidly on to other points regarding the patient's earlier history; no attempt is made to draw the patient on to elaborate any of his symptoms, even though "nervousness" be among them, a blanket term that may mean much or little, depending upon what it signifies to the patient. In these clinics the taking of a detailed history is considered the function of the physician. In other clinics, such as that of District No. 10, Minneapolis, where the taking of the history is purposely designed to save the time of the psychiatrist, an effort is made to obtain as complete an outline of the patient's symptoms, and his notions of the symptoms, as possible. To a trained interviewer, each symptom mentioned by the patient suggests others and these in turn begin to group themselves, suggesting certain definite possibilities of disease. These trends she follows as they develop, keeping always in mind, however, the variety of possibilities any patient may present, and investigating each possibility as far as seems necessary.

An effort is made to secure definite statements regarding the patient's appetite, sleep, habits of daily hygiene, attitudes of mind, memory, power of concentration, emotional stability, disposition, ability to get along with people, likes and dislikes, and recreation; to ascertain whether or not he is subject to headaches, dizziness, periods of confusion, fainting spells; in general, to discover the nature of any fears, anxieties, troubles, delusions, and hallucinations, and the location of any definite aches and pains, whether periodic or continuous; to find out whether the patient believes his condi-

tion is improving or getting worse, whether he has noted any change in his character or habits, and when and how these changes took place. The social worker cannot follow to the end any of the threads she may pick up, for these soon lead beyond her field and the range of her expertness, but she can pick up and expose the threads so that they may be at once discernible to the psychiatrist who will follow them through.

The social worker does not adhere rigidly to outline form, but, taking into account the individual differences of the patients, follows the general trend of the outline in her own mind. It has generally been possible in the district clinic in Minneapolis to secure a large part of the history by letting the patient tell his story in his own way. On investigating the source of the present complaint, it is usually found to be connected with military service. However tedious it may be to the social worker, it is best to lead the patient to give a detailed and chronological story of his army experiences for two reasons: first, for the relief it affords the patient to give expression to the frequently pent-up emotions that are connected with his military experiences; and, second, because practically every man who goes through the clinic has, whether he is aware of it or not, suffered a distinct change in mental or nervous stability with a resultant lowering of his resistance and ability to carry on after discharge, and a narration of his army experiences may reveal how this change took place.

From the military history, it is usually easy to lead further back by such questions as, "How did you happen to enlist?" "Did your parents object?" "What were you doing before you entered the army?" "What were you planning for the future?" It is often impossible to obtain certain details relating to early diseases or to babyhood without explaining that these details are to help the doctor. "A witness once answered a judge who asked him about the weather on a certain day, 'Look here! To drag me so many miles to this place in order to discuss the weather with me—that's——' The old man was quite right, because the detached question had no particular purpose. But when it was carefully explained to him that the weather was of the greatest signifi-

cance in this instance and how important his answer would be, he went at the question eagerly.''[1] Step by step, the social worker must cover the patient's past history until she is satisfied that she has picked out ends of threads for the doctor, for the patient, and for herself to unravel.

Since these interviews must be as different as the individuals whose histories are to be obtained, the underlying facts that the social worker must have in hand at the beginning of an interview relate to herself. Each history is a test of her alertness, tact, resourcefulness, presence of mind, and powers of discernment. She must be objective in her attitude, and must show that for the time being she is interested only in the patient in order to secure the interest of the patient in studying himself. As Gross says, ''No man is interested in a thing unless it is made interesting.''

After the history is finished, an appointment is made for the patient with the psychiatrist. The history is typed and sent in to the doctor early enough to give him a chance to read it before he sees the patient. After the examination, a copy of this preliminary neuropsychiatric history is attached to the medical report and filed in the district office. Carbon copies of each history are filed in the office of the interviewer; in the files of the psychiatric case correspondent, in the division office of the American Red Cross, in cases of out-of-town men; in city cases, in the Minneapolis Chapter of the American Red Cross; with the Federal Board, if the patient desires training; and with the Chief Medical Advisor, Bureau of War Risk Insurance, Washington, D. C., to assist in determining the patient's compensation status.[2]

The methods of procedure in history taking in use at the present time in twenty out-patient clinics of psychopathic hospitals, dispensaries, and districts of the United States Public Health Service throughout the country have been ascertained through letters of inquiry. Although it has been found that each method differs somewhat from every other method,

[1] Gross, H. *Criminal Psychology.* Boston: Little, Brown, and Company. 1915. p. 39.

[2] A sample preliminary neuropsychiatric history from District No. 10, United States Public Health Service, Minneapolis, Minnesota, is given in Appendix II, for which see note 1, p. 97.

there are enough points of similarity to make it possible to divide them into eight groups, as follows:

I. The history, both medical and social, is obtained from the patient by the psychiatrist. A social history from outside sources is secured either through direct investigation by the social worker or from the agency that referred the patient. If a social problem is discovered by the psychiatrist during his examination, the patient is referred back to the social worker for case work.

This plan is followed by the Vanderbilt Clinic, New York City; the Neurological Clinic, Massachusetts General Hospital, Boston; and the out-patient clinic of District No. 6, United States Public Health Service, St. Louis, Missouri.[1]

II. The social and medical history from the patient is secured only by the psychiatrist; but a similar history is obtained by the social worker from the person who accompanies the patient to the clinic. An outside investigation is made upon the request of the physician.

This method was followed by the Boston Psychopathic Hospital before Dr. C. Macfie Campbell became the director, December, 1920. It is used now by the District Clinic, United States Public Health Service, New Orleans, Louisiana, and the Institute of Juvenile Research, Chicago.

III. A fifteen- or twenty-minute interview with the patient is conducted by the social worker to obtain a brief social history, which is typed prior to the psychiatric examination.

This method is followed by the district clinics of the United States Public Health Service of New York City, Boston, and Atlanta, Georgia. (This plan is followed because of an insufficient number of social workers.)

[1] In order to secure social histories for the St. Louis clinic, the social worker writes to the Red Cross chapter in every town or community from which a patient comes to the clinic.

IV. A variety method is sometimes adopted whereby the history from the patient is preferably obtained by the psychiatrist; but if he is busy, it is obtained either by fourth-year medical students or by social workers. Histories are obtained from the persons who accompany patients, and from outside agencies, if possible by the social worker.

This is the plan followed at the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore, and the Cornell Clinic, New York City.

V. A social psychiatric history is secured from outside sources only by the social worker previous to the psychiatric examination.

This is the present plan at the Boston Psychopathic Hospital, under Dr. Campbell, and the Red Cross Neuropsychiatric Clinic, Cleveland.

VI. A social history is secured from the patient by the social worker with no attempt to secure medical data.

This plan is followed in the District Clinic of the United States Public Health Service, Chicago, and in the Clinic of the Municipal Court of Detroit, Michigan.

VII. A preliminary neuropsychiatric history is obtained prior to the psychiatric examination from the patient by the social worker, who secures as much medical and social data as possible. Persons who accompany the patient are also interviewed. (There is seldom time enough to make the desirable home investigation.)

This method is adopted by the district clinics of the United States Public Health Service of Cincinnati, Ohio, and Minneapolis, Minnesota.

VIII. A complete social psychiatric case history, including both the history from the patient and a

history from outside sources by the social historian, is secured before any final diagnosis is made by the psychiatrist.

This plan originated with the district clinic in Seattle, Washington, in connection with the United States Public Health Service hospital in Tacoma, Washington, to which many of the patients are sent for observation.

Upon inquiry, it was found that the methods of history taking indicated in these twenty clinics were not always adopted because they were believed to be the best possible, but sometimes from considerations of expediency; frequently they were judged best from the point of view of the physicians. The third method indicated above was adopted because of a dearth of both psychiatrists and social workers, and is considered by all the clinics using it as a merely temporary arrangement. The physicians of the clinics are all agreed as to the value of the social psychiatric history obtained from outside sources; but the value of the personal history obtained by the social worker instead of by the doctor is debatable.

The first, fifth, and sixth methods are considered best from the medical point of view when there is a sufficient number of psychiatrists to obtain a full personal history. The sixth method was adopted by the Boston Psychopathic Hospital when Dr. Campbell became the medical director, because he preferred that the doctors should secure all social and medical data from the patients, and that the social worker should confine her activity to the outside investigation. The fifth plan is followed by Dr. George H. Reeve, who in his clinic in Cleveland has the services of seven psychiatrists instead of the usual one or two. Dr. Reeve writes:

"Personally, I feel that it is, in the majority of instances, undesirable for the social worker to secure the material for a psychiatric social history from the patient himself. Inasmuch as it is rarely possible for a normal individual to observe without bias, to evaluate correctly, and to report accurately his own habits of response, it is obviously even more hazardous to rely upon information secured from an individual whose mentality may be impaired, whose emotions may be unstable, and whose point of view may be distorted. Furthermore, it would seem that to the psychiatrist alone should the patient be given the opportunity and the stimulus to reveal his inmost thoughts, thus forming the basis not only for a differential diagnosis, but for

the establishment between physician and patient of that relationship without which any attempts at psychotherapy are ineffective. For these reasons, it seems imperative that the social worker secure the data from those persons who, by reason of their connection with the patient, have detailed knowledge of his life and personality.

"On the other hand, the patient is sometimes the only source available, or the circumstances are such as to leave the doctor insufficient time to secure a history. In such cases, the requisite family and personal data are secured from the patient by the social worker, who secures also an account of his illness and his present symptoms without going too deeply into the psychological mechanism. It is interesting to note, however, that it occasionally occurs that the delusional field is penetrated, and, as a consequence, the psychiatrist is able to attack the mental problem more quickly and effectually than would otherwise have been possible."[1]

Under the fourth plan, the social worker interviews the patient first only when the psychiatrist is too busy to see him. Although this method is followed in the Cornell Clinic by both Dr. Clarence Cheney and Dr. John T. MacCurdy, they do not attach the same importance to it.[2] Dr. MacCurdy writes:

"Some social workers are capable of taking an excellent history from the patient which goes into the details of his subjective difficulties, but as a rule such inquiries are apt to make the task of the psychiatrist more difficult. It is, therefore, advisable for the social worker to confine her inquiries to the objective facts of the patient's history, and a trained worker can garner a lot of very valuable information which the psychiatrist can sift."

Dr. Cheney writes:

"By this method the physician has facts available that possibly he would not have time to obtain from each individual patient. The information available to the physician is gone over with the patient and the statements amplified or modified as is necessary. Of course the value of the histories depends not only on those who give the information, but also on the experience of the worker who takes the history, but there is no question in my mind that with sufficient training a very satisfactory history may be obtained by the worker. And I think, as a matter of practice in the psychiatric clinic, that this procedure which we have been carrying out for a number of years is to be commended."

[1] Letter from Dr. G. H. Reeves, Cleveland, Ohio, August, 1921, in reply to letter of inquiry from author.

[2] Letters from Dr. John T. MacCurdy and Dr. Clarence Cheney, Cornell Clinic, New York, July, 1921.

The seventh method, as followed by District No. 10, United States Public Health Service, Minneapolis, has been described in detail. The psychiatrist's report usually begins: "For history refer to preliminary neuropsychiatric history." Dr. Morrison prefers never to see a patient without a history, although he says:

> "If a psychiatrist has the time and opportunity to obtain all the facts that a proper social psychiatric history should present, I believe it naturally would be better than accepting some one else's history. However, this is so rarely the case, especially in out-patient work, that the facts presented by the social psychiatric worker—especially regarding the family situation and the adjustment of the patient to his responsibilities of everyday life—are a material help in diagnosis and treatment."[1]

Dr. J. C. Michael, Chief Neuropsychiatrist of District No. 10, expresses his appreciation of the history taking in the department as follows:

> "It seems to me, first, that in developing in detail a patient's family history—including family traits and tendencies—childhood history, school history, and history during adolescence, during army service, and following army service, noting his diseases, etc., you provide a background that is unquestionably of great assistance to the neuropsychiatrist in determining the character of the case he is dealing with, as well as what measures it is best to institute. Furthermore, these histories become a part of the claimant's file and, therefore, constitute valuable material for future reference. In the rating of disabilities in Washington, I have no hesitation in stating that your histories were of great help, since in reviewing cases it is hard enough to determine with even a reasonable degree of accuracy the extent of the disability. Still further, your histories assist the Bureau of War Risk Insurance immeasurably in the matter of saving the neuropsychiatrist's time; he has consequently more time to examine his case from a medical standpoint. I appreciate the fact that it takes time to obtain a thorough history, and it is certain that the medical man who has to examine many cases would find himself quite handicapped if he attempted to develop histories in as much detail as you have done with your cases."[1]

The eighth plan is the only one by which the social worker secures both the personal and the social history from outside sources. Although the district office in Minneapolis has followed this method to some extent, there were not enough social workers to conduct the outside investigation except

[1] Letters from Dr. A. W. Morrison and Dr. J. C. Michael, Minneapolis, Minnesota, July, 1921.

in emergency cases, when the patient was obviously not giving a satisfactory history. In Seattle, where this method was adopted during the past winter (1920-21), it was considered very satisfactory by both the social workers and the psychiatrists. The examining psychiatrist of the United States Public Health Service hospital of Tacoma, to which the Seattle district clinic sends its men for observation, feels that the service rendered by the Red Cross is invaluable to him in making diagnoses.

Although there is undoubtedly a question in the minds of many psychiatrists as to the value of personal histories secured by the social workers, these workers have been able to help patients through difficulties of a social nature with which the doctor had neither the time nor possibly the experience to deal. This is particularly true in clinics such as those connected with the districts of the United States Public Health Service. A "diagnosis" in an out-patient clinic, even where accompanied by a few words of professional advice, seldom solves the problems of the patient.

A large majority of the men passing through the psychiatric clinic of District No. 10 of the United States Public Health Service were from the farms and small towns of the Northwest, Montana, North and South Dakota, and Minnesota. And because of the differences in their environments previous to their army experiences, they present a widely different problem from that of the city-bred individual, even though their breakdowns may evidence themselves in the same symptoms and receive the same diagnosis of "neurasthenia" or "psychasthenia" or "anxiety neurosis". Out of one hundred cases picked at random from the 458 men who passed through the clinic from October 10, 1920, to August 1, 1921, only 24 per cent had gone beyond the eighth grade in school and 80 per cent had spent all their lives, with the exception of a few months, on farms or in towns of less than three thousand inhabitants. These communities are utterly remote from the complexities of urban life. However wholesome and natural their life may be, it does not fit one to cope with the problems that meet one in the whirl of a modern city, where the fight for existence has become so much a matter of wit and brain and so little one of brawn and muscle.

In an environment of simplicity and calm, these youths attained their majority, sometimes with an animal-like, unquestioning attitude toward life, content with three meals a day, a vigorous physical life, and a good bed; sometimes among them were dreamers who, unable to leave the farm for one reason or another, built up an emotional ideal out of the fictional guides of childhood and the later fictions connected with city life—in which the hero is invariably rough and uncouth in appearance, but, when he does step out into the world, is found to be a "diamond in the rough", who cannot be bribed to lower his ideals, and who finally wins success and the fairest lady.

And so, entirely unfit to cope with the realities of war, but fired with a desire to "make the world safe for democracy" and anxious to prove their loyalty, some of these men, only children at heart, went forth to face the sternest realities man was ever asked to face. And in unfavorable surroundings, with only a few of the crudest tools, they were asked to perform the feat of growing up, of passing through the stages of disillusionment, doubt, and personal readjustment, of building up a new code and a new philosophy, and all in the course of a few weeks—a task such as only a superman could accomplish. And since there were few supermen, the result was disillusionment followed by a rapid downward slide into disappointment, rage, and emotional upheaval. With loyalty uppermost in their minds, they were surprised and humiliated by the casual treatment of what they offered. Having bumped up against reality with its Nietzschean ruthlessness, they came back bruised before they were fully aware of what was taking place, with a resultant cynicism and a repressed or an open affective undercurrent of hatred and rebellion due to their lack of background and the briefness of their experience. It is not strange that the refrain of every ex-soldier who came into the clinic was, "I am not the man I was before I went into the service", and that, when asked to tell what happened to them in the service, so many of them replied, "I would rather not talk about it"—a conscious effort to repress painful memories.

Most of these men come to the Public Health Service clinic reluctantly and defiantly, with the idea that they are to be

treated in the usual quick and automatic way by this great machine, the government, with its never-ending red tape, that thinks it can in some way compensate them for the ills that have befallen them. And, all prepared to find every conceivable fault, the soldier of this type finds plenty, and usually opens his interview in the Red Cross office with a disagreeable and defiant tale of how he has been treated since he came to town three days ago—how he waited in line hours while other men were handled immediately; how the Public Health Service doctors slumped on the job, came in late, did not seem to know their business, and treated the men like dogs; how the tickets they were given for meals and lodgings were not respected because the government was so slow in refunding them—an unending list of grievances.

Especially irritated is the man referred to the psychiatric department, because of the type of his illness. He is distinctly surprised to find some one ready to stop and discuss in a leisurely and sympathetic way all his difficulties and small grievances; some one who, knowing where the fault largely lies, is able to show him how he himself has misinterpreted some things and misunderstood others, but who can see and understand the justice of some of his complaints and is willing to try to set these things right. It is by no means an easy or an unimportant task to show the sorely disgruntled patient that there is, after all, a human element in what he thought was only a machine, and thereby gain his coöperation for the future. And neither irritation nor despair are to be wondered at when one stops to realize what it must mean to these weary men to push through red tape that would appall even a strong, healthy person. A well person might easily develop a "headache" before reaching the last task imposed by the government in dispensing its compensation.

The ex-service man who comes from the city is often much more difficult to approach because of his *savoir faire,* his suspicion of social workers, and his desire to keep his past well hidden from prying eyes. If he is of the group of casual laborers, he very early came into contact with the realities of life, and although he may have been "a football of his environment", his knocking about began so soon that he has built up a strong defense mechanism. He is usually willing and

able to talk well, and does not hesitate to express his views on every subject but himself. To obtain the real facts of this patient's life requires discernment, as he is likely to color his story in proportion as he thinks it will impress the person before him.

The following cases are instances in which the interviewer was able to be of immediate assistance to the patient when it is possible that the psychiatrist, through lack of time if for no other reason, could not have helped in the same way. In other words, the social worker, knowing the problems facing the patient because of her direct contact with him through her interview, was able to supplement the psychiatrist's diagnosis and professional advice by putting into motion the machinery, governmental or otherwise, calculated to meet in an immediate and practical way the personal problems presented and thus free the patient from some of the meshes in which he had been caught.

1. H. L., aged 25, came into the office much worried, and sat on the edge of his chair in a hesitating manner. He was unwilling to answer questions at first, and asked several times if this interview was necessary. He had been taking vocational training for two years in salesmanship, and had just been tried out by a tobacco company for a few months; but because of the state of his mind, his inability to stick, and his indecision and lack of self-confidence, the company had not thought that he would make a success of selling. The Federal Board was giving him a thirty-day sick leave to rest up, but he was worried because it was time for his training to end, and there was no selling job ahead of him. He was very disconsolate and could not settle his mind on any point long enough to give a satisfactory answer, but said, "If I answered that question, I would be condemned as a ne'er-do-well." He twice started to leave the room to smoke, and changed his mind a dozen times about going to the hospital to rest. He reiterated that he knew it would require only his will power to rid him of his fears and hesitations.

As soon as he found that the answers he gave were not going to influence his chance of securing a job, he was more willing to talk. He asked if the interviewer was interested in Christian Science and then told how he had become interested in it. He explained that he had lost his self-confidence and knew that other people thought him inferior. His parents had felt that he was "sponging" on the government because he accepted vocational training, as he had been discharged before his troop went overseas because of a lame foot, from which four inches of bone were removed in his childhood.

He had been restless and discontented from the time he was eighteen, at which time his father had married again and the patient had begun

to regret that he had not finished high school. When he was twenty-two, he had married a seventeen-year-old girl whom he had known only ten days. Because of coercion by her parents, she had left him after two days, and he had secured a divorce on the ground of desertion. This had made him unhappy for two years. When he had begun training in a field he really liked, he had hoped to get the better of his shortcomings, but, instead, he was worse than before.

When he left, he stood at the door for some minutes and asked the interviewer to repeat several times what she thought he should do. He said that every one was tired of his complaints, and asked if he might come often until he felt capable of making his own decisions.

From February until March, the patient came to see the social worker at least once a week. He was unable to find a selling job after he came out of the hospital and refused to consider other types of work. He finally took a business course to keep him busy until he could find work. In the meantime, he became disconsolate over an affair with a Catholic girl, who would not respond to his advances because he was divorced. After discussing the feasibility of adopting some other occupation, steadier and requiring skill rather than self-confidence, the patient finally announced that he had decided to take up mechanical engineering, a two-year course under the Federal Board. He had at first believed that he was too old to start a new trade. The Federal Board granted him the training and within a few weeks was pleased with his growing self-reliance. By July he was cheerful and independent and had begun to call upon a girl whom he had met at business college.

The psychiatrist's diagnosis in February was: "Psychasthenia. Suggestion of paranoid trend in some of his statements."

2. C. H. B., aged 22, a neat youth with cross eyes, appeared blue and perplexed when he entered the office. He had asked for a mental and nerve examination because he had felt increased "nervousness" in the form of worry, fatigue, and insomnia during the month. The work that he had given up two weeks before to take up vocational training had been very hard, as he had been head bookkeeper in a wholesale house with six or seven people under him and an immense amount of detail work. He was having a good deal of trouble with his eyes, as one eye turned too far to the side and his glasses did not sufficiently correct this defect. In addition to his regular work, he had been taking the night law course at the Y. M. C. A., and he was expecting to take up the night law course in the Minnesota College of Law under the Federal Board. He was worried because he would have to work all day in a law office, as well as take the night course, in order to be entitled to the Federal Board allowance. He realized that he did not know enough law to profit by the work in the law office. In order to make the course worth while, he had planned to study at least five or six hours a day. Since he was inclined to be over-conscientious, he knew that he would break down under such a severe strain.

When the interviewer promised to take the matter up with the Federal Board to see if arrangements could be made for him to report for study at certain hours, he was surprised and delighted at the interest evinced in his welfare, and was soon sitting with both arms on the desk, eagerly

giving an account of himself. He had gone to business college after high school because he had not wanted to be a burden on his parents long enough to take a medical course or go to law school, but he had always planned to go further as soon as it should be possible. He was very profuse in his thanks to the interviewer for offering to help him, and said he had been very blue about his situation, and just on the point of giving up the idea of studying law and trying to find a job again.

The doctor made no diagnosis, but said that the patient was conscientious, introspective, and nervously overtired. He recommended that he be permitted to stay out of the law office four or six weeks.

When the matter was talked over with the Federal Board, it was found possible to make arrangements for the patient to be nominally placed in a law office with the understanding that he was to have the time for study and certain hours during the day for recreation and rest. Under this plan, he did splendid work.

3. J. L., aged 25, married, gave an impression of honesty, but was shy and self-conscious. He had heard of the Public Health Service only two weeks before, and had had no medical care since his discharge because he had not been able to afford it. He had always been healthy until he had entered the army. He had finished only the eighth grade in school because his father, a German farmer, would not let him go on and take a course in mechanical engineering. He had been with a company of Marines who had sailed for France in July, 1917. Five thousand of their eight thousand men had been killed in the big drive on Paris in June, 1918, and the patient had been "shell-shocked", after which he had been deaf and dumb for six weeks. He had had severe headaches and fainting spells from that time on, and had sometimes been unconscious for a half hour; but he had never had a convulsion or bitten his tongue. On returning from France, he had thought he was getting better and had married. At the time of the interview, he was depressed because his health seemed to be getting worse and his memory was so poor that he could not remember messages or errands without writing them down. He had not been able to stand hard work when he returned, and had finally been forced to work in his father-in-law's rubber company, where he was a combination janitor and errand boy for $21.00 a week.

He was worried because he was not able to do even "roustabout" work efficiently, as he could not work steadily for more than half an hour without having to leave for five or ten minutes to steady his nerves. He could see that it was irritating his boss, although the boss was nice enough after work; but the patient began to feel that he was inadequate. He had reached a point where he hated to meet people and was always too tired to care about anything. His wife was to be confined very soon, and he was worrying about the expense, as he hated to be indebted to her father. When the interviewer suggested the possibility of Federal Board training, the patient had not heard of it. When he found that it would be possible for him to take the course he had always wanted in mechanical engineering and at the same time receive $135.00 a month, he was surprised and much relieved.

The psychiatrist made a diagnosis of "hysteria", gave the patient a long talk on how to control his nervousness, and recommended vocational training.

With the aid of the interviewer, the patient was started in his course in mechanical engineering the following week, and was granted a sick leave of thirty days. When the interviewer next saw him, two months later, he had on a new suit and wore an air of self-possession. He stopped in at the office a moment to say that he had had enough money to send his wife to the hospital for her confinement, that both she and the baby were doing splendidly, that he enjoyed his training, and that his own general health was improving.

While it is undoubtedly a splendid plan in many instances for the psychiatrist to make the first contact with the patient and, after finding out the social problems, to talk the matter over with the social worker, advising her as to methods of procedure in treatment, it is a plan for a city clinic rather than for a clinic that handles patients from a wide territory, where the social contact must be made by mail. If a patient, for example, has been in the city for several days awaiting an examination, he is not likely to wait, after the final consultation, for any sort of a secondary interview with a social worker. (It is sometimes impossible to hold a man long enough to see the psychiatrist himself.) And unless the social worker did see the patient before he set out for his home in Montana or North Dakota, she would be forced to handle the case far more theoretically and consequently with great difficulty, even if the psychiatrist advised her as to the problems involved and the best methods of handling them.

Although practically every history taken in the office of the Public Health Service in Minneapolis uncovered a variety of problems of every degree of complexity, there were no workers to carry on the case work, and the majority of problems were left unattended to and increasing at a rapid rate. An attempt is made in the following cases to indicate some problems that might have seemed too trivial for reference to a social worker, or might not have been noticed in a short conference following the psychiatric examination, but that, under the stimulus of assisting the doctor, the patient revealed to the best of his ability. In such cases, unless the doctor wrote a complete history for the social worker to consult before her visits, or else spent a long time discussing the problems of

the case with her, she would not be able to get an adequate picture of the situation.

1. C. A. A., aged 25, was a slouchy, untidy chap, who dragged his right foot and enunciated thickly. His left arm was paralyzed. He was bold and facetious. His moral turpitude was amazing; he boasted of the fact that he was utterly irresponsible and he delighted in telling the horrid incidents of his life—his loafing and stealing as a boy, his sentence in the Red Wing Reformatory, his associations with immoral women. When he was eighteen, he had entered the army, had tried to desert, had been shot at by a sentry, and had "almost been sent to Leavenworth". He stated that he had been married three years before to a sixteen-year-old girl, but that she had left him after one year; that it was none of his wife's business what he did, and that he blamed her for leaving him. He stated also that he had below a motor cycle for which he had paid $800.00, and that the next episode in his life was to be on a motor cycle.

The psychiatrist's diagnosis was: "Right spastic hemiplegia and spastic gait. Left cerebral thrombosis with right hemiplegia, syphilitic." He recommended that the patient be hospitalized "in view of the marked lowering of his moral tone and the colloidal gold curve occurring largely in the paretic zone".

An interview with the wife showed her to be unusually attractive and intelligent. Her life with the patient had embittered her against all men and women. She did not know that the patient's actions were due to illness, and she hated him for all the misery he had caused her. For over a year, she had been paying $10.00 a week for syphilitic treatments for herself because she would not go to a "free dispensary". She would not let her parents know of the shame caused her, and was working in a restaurant in the most vicious part of the city as cashier. Her hours were from 4 p. m. until 2 a. m. She was accustomed to returning home alone, and she was "afraid of no one". She would like a divorce, but could not afford to get it, and would not ask her family for money. She was on friendly terms with the patient's parents, who had no idea why the two were living apart.

The problems of hospitalization for the patient and education of the wife to an understanding of the situation, so that she would be willing to accept treatment, would give up her cold attitude toward the world, and would make an effort to secure a divorce and see her family, are evident. It is evident, also, that the girl would need advice and guidance for some time, and that the family of the patient would need assistance in meeting the situation of their son's illness.

2. G. B., aged 25, single. Although this man was reported as a malingerer, his attitude belied this report, as he was willing to tell facts he might easily have concealed. He appeared rather wistful at times, and again defiant. His parents had died when he was three, and he had been reared by an aunt and uncle until the age of ten; then he had been left to shift for himself because he had not got along well with his aunt. She had tried to "boss" him, and he had always been independent and stubborn and had resented authority. One of his teachers once

said, "You will be in the penitentiary sometime." From the age of ten on, he had worked in the north woods, where he had been everything from a cookee to a road boss. He had been as "hard as nails" when he enlisted in the army, and had enjoyed army life until his accident in France. A French army truck had collided with his motor cycle, and had run over his body, fracturing a vertebra so that he had been forced to lie flat on his back for two months. He had become restless and irritable under his confinement. After his discharge, he had found that, as a result of the injury to his back, he was unable to do the hard work he had done before. He had tried to take vocational training in bookkeeping to help him in the lumber business, but had not been able to concentrate on the lessons. A vacation of six months had been ordered by the physician, with the plan that he should take up forest-ranging in the fall. He was receiving only $8.00 a month compensation, and had few friends to whom he could go for money to tide him over until fall.

The psychiatrist did not believe that the patient was a malingerer, but thought that his symptoms were very suggestive of a psychoneurosis. He advised a summer's vacation with forestry in the fall.

Here the obvious problems are those of the patient's loneliness, his difficulty in getting on with others, his trouble with his relatives, his financial difficulty, and the question of how to manage a vacation for him over the summer.

3. C. M. O., aged 26, married. This patient appeared unintelligent and dull during the interview. His mother had died in the Rochester State Hospital when he was six, and he had been reared on a farm, with thirteen brothers and sisters, by an older sister. He had stopped school in the third grade, when he was fourteen, because "it was kind of hard for me to learn". He was ill when he started overseas, and he had become "nervous" and depressed. He had been taken off the boat at Halifax, and shipped back to New York. He had been in a hospital for eight months, in a closed ward with patients who were "more worried" than he "and so acted crazier". His brother had been sent East to bring him home. His memory had cleared up pretty well after that, but he had had hemorrhages of the lungs six times after discharge. He stated that he had been married a year and a half, and that he had a two-weeks-old baby. He was receiving $40.00 a month compensation, his only source of income. He was living with his wife and baby in a two-room house that he had rented five miles from town. There was no land connected with the house, and he tried to do livery work with his Ford. As there was little to do, he spent most of his time loafing around town. He did not worry, as his wife never said anything when he ran out of money.

Diagnoses of dementia praecox, catatonic type, and pulmonary tuberculosis, both improved, were made by the psychiatrist and the internist.

Difficulties in regard to health, finances, and ability to carry on are marked. A home investigation is imperative, to observe conditions of sanitation, to find out if the wife is capable, and if the baby is being properly cared for. The doctor's attention should be called to the presence of the baby, as its health may be endangered by the father's tuber-

culosis. A definite effort should be made to have the patient's compensation immediately increased; and if his physical condition does not make it inadvisable, an arrangement might be made for renting a few acres of land near the house for farming. The course of both his physical and mental condition should be followed, as a change that may completely incapacitate him and leave his family helpless is not an unlikely event.

4. S. T., aged 24, single. This patient sauntered in under a wide sombrero. He had a quick grasp, and talked intelligently, although his tongue seemed to be thick and hard for him to manage. He had been proving up on a homestead in South Dakota, and had had some difficulty because of his "absent-mindedness" in misplacing tools. He had always been very healthy until he had entered the army. He had left school in the seventh grade because he had wanted to work, and at the age of fifteen had begun helping his father on the farm. He had enlisted in the army during the Mexican trouble in 1916, and had been well until the spring of 1918, when "the heat seemed to go to my head". He had felt confused for about six weeks before he had been sent to the hospital, had never been "mean", but had done "queer" things. He had imagined all sorts of things—that people were all interested in his affairs, that some of them were detectives, and that they were putting poison in his food, so that he would not eat. He had been sent to the base hospital one day in May because he had not turned up for drill. Although he had been transfered from the base hospital to a state hospital and had remained for six months, he had been in a closed ward for only six weeks, and had soon begun to realize that his "imagination had been working too much". Soon after his discharge from the hospital, he had gone out West, because "all my friends and relatives know I was in the bughouse". He said he would give a million dollars to efface that time in the hospital—that it often bothered him when he was tired and made him wretched. He read a good deal to keep his mind off of himself. Except for his previous trouble, he would like to go back home and take up Federal Board training. He was planning to marry in the fall.

The first problem here is to get enough social history by correspondence with his home town in Indiana to make clear the nature of his psychosis, as the psychiatrist reported: "Psychosis, type undetermined from evidence at hand; possibly paranoid dementia praecox." Further problems are the surmounting of the patient's sensitiveness, reuniting him to his family, and gaining the coöperation of the family by helping them to understand the nature of his illness; close supervision of the patient for the purpose both of protecting and guiding him and of noticing any change in his condition that would require further medical advice; and investigation of his plans for marriage and consultation with the physician and his family as to its advisability.

5. G. M., aged 44, married. This patient told a "hard luck" tale. He had stopped school in the eighth grade at the age of seventeen because he had been blamed for something that he had not done, and when the teacher had tried to punish him, he had become angry and had quit. He

had always been easy-going and so kind-hearted that during his entire life he had constantly been blamed for things he had not done, and had not cared to get into trouble about them. He had worked most of his life on the railroad, first as fireman, then as brakeman, and later as conductor. In 1911, after nine years on the Great Northern, he had been blamed for a wreck for which he had not been responsible, and had been blacklisted. Although he had had only one drink, he had been charged with intoxication. The wreck had not been serious. He had been idle for almost a year; then had secured a job on the Canadian Northern Railroad out of Winnipeg. After fourteen months he had returned to Minnesota with good references, and had again been permitted to become a brakeman. While in the army, he had suffered from a sunstroke, after which he had been dazed and confused for a week; he had also been ill ten days with ptomaine poisoning. After discharge, he had had stomach trouble continuously. He had been extremely restless and discouraged because he had been unable to work. He had begun having some domestic trouble, and his wife had thought that he was lazy. He had gone away for several months to find work, but had been too discouraged to write home. When he had written to his wife, she had stated that she was getting a divorce. He had returned, and although she had promised to give him another trial, she still blamed him. She had finally dropped the divorce proceedings when he had been accepted for vocational training.

The patient wept frequently during the interview, and said that he had not been to blame for his trouble. He believed that his discontent and restlessness had been increased by the fact that he had never cared for any work except railroading.

The psychiatrist made no definite diagnosis.

The most important problems in this case are the patient's health and his family trouble. An investigation should be made to secure more objective data on the situation for the physician; and if things are as the patient says, an effort should be made to bring the wife to realize that her husband is really ill and that he should therefore be treated much more tolerantly and kindly than if he were well.

6. W. M., aged 26, single. This patient was quite cheerful and accessible. He said that he was blue only when "things are not where I can handle them"; he was very vague as to what he meant by that. He had lived on a farm all his life. When he was sixteen, he had finished the eighth grade, and after that he had helped his father because his father could not afford to get help. His mother had taught a union Sunday-school class in the schoolhouse and the patient had always enjoyed that, but he had never cared for rough games. He had always been tender-hearted and easily hurt. He had felt very sorry for the "innocent children in France with their hands and feet cut off". He had been drafted into the army because they would not take him when he had tried to enlist. He had gone overseas in August, 1918, and in September had come down with an attack of influenza that lasted for six weeks. Two weeks after he had returned to his company, he had been sent back to the hospital because he was "nervous" and weak. He had been in a closed ward for one month. On his return from France

he had been sent to the hospital at Fort Benjamin Harrison for eight months. He had not minded being in a closed ward, but he "did not like the way the people fought". Since his discharge he has been able to help his father and had been well, only more short-winded than before the war. The fact that he was receiving only $8.00 a month compensation, that his father was poor, was renting the farm, and was having poor crops, did not bother the patient.

The diagnosis was: "This is probably a case of dementia praecox. [This diagnosis was made after the patient had been under a period of observation in the army.] Since he prefers continuing farm life, this would probably be as satisfactory a life as could be suggested for him."

The family situation should be investigated to find out if conditions are satisfactory for caring for the patient at home. An immediate effort should be made to secure for him an increase in compensation.

The opinion would seem to be unanimous that whether a personal history is obtained or not, a social history is essential, since a person is the product of his environment and cannot be completely understood apart from that environment. The fact that a patient does not always play the game squarely, and purposely either gives false statements or refrains from giving valuable information, is evident when the social histories from outside sources are obtained. Even if he does not purposely give a false impression, an objective point of view of the patient must be obtained elsewhere.

The following histories show of what slight value the information given by the patient may be, both to the psychiatrist and in the field of social research, unless followed up by corroborating data from outside sources. Not infrequently an outside investigation leads to a change in diagnosis, or, in a case where there has been indecision on the part of the psychiatrist, enables him to make a diagnosis. If it is to be used for statistics in the field of research, too much care cannot be taken in securing detailed, thorough, and verified information. The use of unverified data for the purpose often proves tempting, but results in a collection of misleading and worthless statistics.

1. G. S., aged 27, single. Although the patient appeared to take the interview seriously and to talk frankly about himself, the information obtained later from his mother did not bear out his statements. He had stated that there were no mental or nervous diseases in his family, but it was found that his mother was rather "nervous" and excitable, and that a paternal aunt had died in the Rochester State Hospital. He had omitted the information that his mother had been seriously ill

before and at the time of his birth, that he had had spasms from the age of six months to one year, and that between the ages of seven and nine he had had a severe illness, at which time the doctor had said that he would not grow up mentally strong. The patient's story was that he had had no trouble with his teachers, but had stopped school in the eighth grade because he had been "eager to work", and that after farming for two years, he had worked steadily in a printing shop until his army service. His mother gave the contradictory information that he had not been able to get along well with his teachers and that he did not stay long in any place of work, as he tired easily. The patient said that he had been healthy from the age of seven until he entered the army at twenty-four. His mother said that he had had his first "nervous breakdown" at nineteen, when he would come home from work stating that his fellow-workers had been unkind to him and had made work difficult. Later he had become worse and had thought that his family were unkind. He had then developed "more delusions", and had been committed to the Rochester State Hospital, May 16, 1914, with a diagnosis of dementia praecox. He had been discharged as recovered May 8, 1915.

Although the patient gave a correct account of his breakdown in the army, his ideas of grandeur, and his auditory hallucinations, he also stated that he had felt his trouble coming back only once since discharge, when he had been "out of the head" for two weeks. His mother said that he seemed to get along well until he became worried or tired physically, when he would have strange ideas, talk irrationally, and sleep for hours. He remained sensitive about his condition, and was seclusive. When one of his spells was coming on, his face would become suffused with color.

With only the history from the patient, the psychiatrist was unable to make a final diagnosis, stating that the patient was probably in "a free interval of manic-depressive psychosis; but the possibility of dementia praecox, which has shown marked and exceptional improvement, cannot be absolutely ruled out." With the additional information from the patient's mother, a diagnosis of "dementia praecox" was made.

2. H. A. D., aged 22, married. The patient impressed the interviewer as being an unusually well-mannered and pleasing young man, anxious to do anything in his power to get well. Although he had gone to school very little, and had never held any job for any length of time—in fact, had "been a regular hobo"—he seemed to realize his shortcomings and honestly to wish to study "so that I will amount to something". Questioned as to traits and habits, he stated that he had a quick temper, was not a good mixer, worried about his physical condition, and was very ambitious. He had never smoked, never tasted alcohol, and had had no sexual irregularities. He stated that he was rather lonely, as he did not know many people and his stepfather was uncongenial. The Federal Board had just granted him training, and he was expecting to go to business college. His troubles were due to "nervousness", weakness, and pains in his stomach, the result of working all day every day for eight months in a refrigeration plant in France during the war.

After discharge, he had been operated on for appendicitis, and the wound had never properly healed.

The diagnosis made by the psychiatrist after this first interview was "anxiety neurosis".

An interview was later held with his mother, an unrefined woman of average intelligence, whose reliability was effected by her emotionalism and a tendency to exaggerate. She stated that the patient's father had had such violent fits of temper that he used to lose entire control of himself, and she had left him when the patient was six years old. She had not had any particular trouble with the patient until he had returned from the army, at which time he had seemed greatly changed. Not only was he nervous and irritable, but his habits were also changed. He was lazy, insolent, mean-tempered, and stayed out late with rough women. In December, 1919, he had married a low type of woman much older than himself, who had been living two years as the common-law wife of another man. He had told his mother that he married her to get even because his mother had married such a mean man as his stepfather. The patient's mother hated his wife, but she had been forced to give her money for support as the patient could not work. She had used up all her own savings, as her husband had absolutely refused to help his stepson. In November, 1920, the patient and his wife had gone to Milwaukee, where the patient had become ill with appendicitis and his wife had left him. When he had gone to the hospital, his mother had gone after him and had brought him home. After that she had led a life of torment. The patient had a mania for getting hold of money, and would have violent fits of anger if she did not give it to him; he would draw his face into menacing contortions and jump at things to throw at her. He always spent the money foolishly on women, or gambled it away. He spent his bonus check for a new Victrola, and would lie abed all morning listening to it. He was too ill to go to business college most of the time, but refused to give up his dissipated life.

The diagnosis made by the Federal Board psychiatrist and the United States Public Health Service psychiatrist, after the supplementary histories were received, was "constitutional psychopathic inferiority without psychosis".

3. W. H. M., aged 23, single. The patient was coöperative, friendly, and intelligent during the interview. He complained only of restlessness and of weakness following an attack of influenza he had had in the army. He had always been healthy before that, but "inclined to be a little gloomy". He had completed two years of academic work at Carleton College, Minnesota, prior to his enlistment. After his discharge, he had attended the University of Minnesota as an auditor until the end of the semester, at which time he had entered as a regular student in the College of Law. He had found the work more difficult than the regular college work, tired easily, and had difficulty in concentrating his attention on what he was doing. He had left school after four months because of continued "ill health". He had tried working in his father's store, but had become too restless, and had done nothing after that time.

The information obtained from the patient's sister, who seemed truthful and intelligent, was that before the patient had entered the army, he had always been particularly fond of and "chummy" with his mother. But at the time he had had influenza, he had stopped writing to his mother and had written only to his brother. Upon his return to Minneapolis, he had not mentioned his mother's name. When he had returned home, his mother said that he would sit and look at her with a queer, strained look on his face and would say, "You will be sorry for this some day! You will get your punishment!" He blamed her for the illness he had suffered while in camp. His family thought that he was lazy because he took no interest in work, whereas prior to this illness he had been the brightest, most alert member of the family. While he had been at Eitel Hospital, he had left without warning, and twice had escaped from the Minneapolis Sanatorium. He had attempted to obtain a revolver, had threatened his mother with violence, and had written insulting letters to all of his friends and relatives. After his return from the hospital, he was extravagant. He had disappeared from home for three months, but had returned when his money was spent. On his return, he would not speak to his mother for a time, but later had been persuaded to do so. His sister believed that he realized that he had been "mentally unbalanced", but that he would not admit it because of a feeling of shame. He never mentioned that he had been to the sanatorium or told any one of his mental difficulty.

A diagnosis of "dementia praecox" was made by the psychiatrist, with the stipulation that the patient should not be placed in any position of responsibility, and that he should be kept in good physical condition.

4. L. L., aged 23. Marital status uncertain. This patient was an attractive young Jew who entered with a blasé attitude and was very anxious to impress the interviewer with the fact that he had been reared in New York, had been a very famous prize-fighter, and had been thrust into his present position because of his patriotism. He laughed at most of the questions asked him, and did not seem inclined to take any of them seriously, seeming to think it should be evident by his appearance what the answers would be. Since the interviewer had in hand a social history forwarded by the Home Service Section of the American Red Cross of Brooklyn, New York, it was possible to follow his story and know when he was making false statements.

Most of the personal history he gave was verified by the history from Brooklyn. His family maintained the high standard he had ascribed to them; but one sister, who the patient said was in good health, was suffering from "hysteria", and hospital observation had been advised by a psychiatrist. Although the patient gave a detailed account of his army experiences—of being gassed, wounded, and "shell-shocked"—he insisted that he was always sane, but "nervous" and restless, and that he was always fighting to keep away his depression. The report from Brooklyn stated that the patient had left the hospital in Hampton, Virginia, A. W. O. L., and that the War Department had sent a letter to his father stating that the patient was "mentally defective".

The patient stated that he had remained in Brooklyn for two years after his discharge, attempting to get into shape for fighting again, that he had not left until he had gone out to Billings, Montana, to fight. There he had lost his reputation entirely, by losing three fights, and had been told by the doctor never to try fighting again. The Brooklyn history stated that soon after his discharge the patient left for Paris, telling his mother that he had promised to marry a girl whom he had met overseas. Five months later, his mother had received a letter from him dated April 18, 1920, and written from Prison La Saute. He had merely stated that he had married and wanted $250.00 to obtain his release and pay his wife's and his own fare back to New York. The Red Cross had persuaded her not to send the money until an investigation had been made. On June 18, the Paris Red Cross had sent word that the patient had been released from prison and forced to leave France. He had refused to return home, as his wife would not be permitted to enter the United States. She was a licensed prostitute, and had been keeping the patient during the time they had lived together; this was the cause of the imprisonment. There was no evidence of any marriage ceremony, but there was a paper signed by the girl's parents, giving their consent to the marriage. A child had been born, and the girl had claimed the patient as its father. The baby had died when only a few months old. The next time his mother heard from him, the patient was in Montana.

The patient had insisted that he had never married, and that he had never been dissipated, because he was forced always to keep in trim for "fighting".

The psychiatrist reported on this case that "in view of the conflict between the preliminary history and the social history, it would be desirable for this patient to be committed to the Neuropsychiatric Service of the United States Public Health Hospital for observation. A diagnosis of constitutional psychopathic inferiority is to be considered in this case."

In her description of the first interview, in *Social Diagnosis,* Mary Richmond gives a clear picture of what a first interview under usual conditions in handling a social problem should be. What she speaks of as ideal conditions are only the usual conditions of an interview carried on in the manner prescribed in this paper. Miss Richmond is speaking of the interview held with a client in a social agency, but what she says applies equally well to the social interview held by the worker in a psychiatric clinic. The objects of the first interview in any case should be "to give the client a fair and patient hearing; to establish, if possible, a sympathetic and mutual understanding as a good basis for further intercourse; to secure clues for further sources of information; and to begin the slow process of developing self-help and self-

reliance, though only by the tonic influence which an understanding spirit always exerts, and the realization that later the client's own level of endeavor will have to be sought, found, and respected".[1] Again, Miss Richmond says: "Patient's own hopes, plans, and attitude toward life are more important than any single item of information." The quotation that she uses from Adolph Meyer applies equally well:

> "For any examination, the mode of approach is absolutely decisive of the result. The reserve of the patient is usually a factor to be reckoned with, or at least the unwillingness of the patient to show a clear picture of decidedly peculiar experiences. It is, therefore, necessary to gain the confidence by treating the patient 'as a sensible man or woman'. In perfect privacy, and, as Head says, with the choice of a quiet and confidential hour and the precaution of changing the subject when irritation begins to adulterate the account, and before the patient has been exposed to the influences of the ever-present blasé fellow-patient, the statements can usually be obtained quite fully, often with a feeling of relief in the patient and a distinct gain in the relation between physician and patient. That any chances for self-humiliation must be eased with verbal suggestion, and that any appearance of obnoxious ridicule or dictation or correction and unnecessary argument must be avoided, should not require special insistence. It certainly requires a good deal of knowledge of man to choose the right moments and it is to such an extent a matter of inborn tact that it is doubtful whether any written rules can do more than bring out in a more definite order that which one has already."

The interview held by the social worker in the clinic previous to the physician's examination differs not in purpose, or in method of procedure, but in its greater opportunity to get over to the patient in a tactful manner this willingness to be helpful. The plan of procedure worked out in the Minneapolis clinic increases this opportunity for several reasons: there is a private office where every history is taken without interruption or distraction; the patient expects certain questions to be asked of him because it is part of the physician's examination, so no excuse is necessary; there is plenty of time for a long, unhurried interview, if necessary, as the social worker has so planned and the patient so understands. An appointment is made with the psychiatrist and the patient

[1] Richmond, Mary E. *Social Diagnosis.* New York: Russell Sage Foundation. 1917. p. 114.

knows that he cannot see him until the specified time. The social worker under these circumstances has proper and substantial backing in her approach to the patient in that it is clear that her relation to him is a professional one and that the only object of the interview is to help him by helping the physician more quickly to the essential facts in his condition. On the social side, a proper kind of contact is made in that the social worker enters the situation at a time before the patient's pride has been degraded and he has been forced to descend to a level where he must ask for charity. The settlement-house plan of reaching the individual first through social contacts and building up a basis of understanding through meeting and knowing him in his natural environment is very near to being reached in an interview of this type, in which social problems come up as a natural step in trying to ascertain the causes of physical and mental maladjustments.

Although among psychiatrists there is a difference of opinion as to the value of the personal history taken by the social worker when this history includes the present complaint and the subjective attitude of the patient, the question remains whether it is not a time-saving device as long as the number of psychiatrists is limited. As the development of the procedure is recent—it seems to have been practiced only during the past year—not enough data could be secured more than to indicate that, from the point of view of the social worker, this means of building a foundation upon which later social case work can be constructed is superior to some other methods. A procedure, however, that is handicapping to the psychiatrist, even though it may have advantages for the social worker, cannot be continued. This would be to get the cart before the horse. In the present instance, however, force of circumstances—busy clinics with too few psychiatrists—will no doubt make necessary the continuance for a time of the procedure outlined here. A larger experience will make clearer what the advantages and disadvantages are. In general it may be said, however, that the greater the opportunity given to the social worker, whether by permitting an initial interview or otherwise, to obtain as comprehensive an understanding as possible of the patient and his problems, the more effective will be the assistance she may render both

to the psychiatrist and to the patient. Alone, the psychiatrist finds himself balked in understanding his patient thoroughly because of the meagerness or unreliability of the information he has in regard to the life of the patient; later he not infrequently finds himself facing defeat, for although he has formulated a plan by which the patient may be rehabilitated in the community, he has no means of working out the practical details of the plan and, if he did, no way of carrying out the plan. It is at these two critical times in the relation of the psychiatrist to the patient that the trained worker can come to the aid of both. She can obtain the information needed, and the working out of the practical details of a social plan and the discovery of the means for carrying out the plan are procedures in which she has attempted to make herself skillful. But she cannot work in the dark. The fuller her understanding of the special problems and particularities in any given case, the greater will be her ingenuity and resourcefulness and, therefore, her effectiveness.

CASE CORRESPONDENCE: A METHOD OF PSYCHIATRIC SOCIAL WORK*

A Study of the Plan Developed by the Liaison Staff in the Central Division of the American Red Cross in Minneapolis, Minnesota

ELIZABETH C. HAYES

THIS study is planned to be a brief description of an attempt at psychiatric social work with a group of ex-soldiers distributed over a large, rather sparsely populated territory, consisting of the states of Minnesota, North Dakota, South Dakota, and Montana. The work was done through correspondence from a central office with the Home Service sections of Red Cross chapters in the counties of these four states. The system adopted was the one already used in the Northern Division of the American Red Cross, Department of Civilian Relief, in dealing with the Home Service sections in regard to all problems connected with the men while they were in the service and after they were discharged.[1]

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[1] "In general the duties of Home Service in relation to the rehabilitation of disabled soldiers and sailors may be summarized as follows: (1) To bring solidly behind the disabled man at all stages of the reconstruction process the moral support of his family, remembering that he is at this time just as much in the service of his country as when at the front. (2) To assist the men, through the competent legal service at the command of the Home Service Section, to secure the benefits of the War Risk Insurance Law and especially the provisions for compensation and insurance. (3) To urge upon disabled men, as opportunity presents, the wisdom and necessity of taking full advantage of the government's plans for their care and training. (4) To encourage them in the early and critical stages of their vocational training and of their return to employment, when the struggle to overcome the mental and physical handicap is most acute. (5) To bring about a reasonable and sympathetic attitude on the part of employers, which shall give every handicapped man a real chance, while avoiding the danger of tempting him to forego the necessary training for the specious attraction of an immediate, temporary, or perhaps unsuitable job. (6) To mold public opinion so that it will discountenance trivial and demoralizing entertainment and hero-worship, and maintain a constructive attitude which, while demanding a square deal for the returned soldier, shall expect from him every reasonable effort to insure his self-support. (7) To supply information,

The work was carried on as part of the activities of the Department of Civilian Relief. The correspondence work of this department was organized into a unit at the time of the consolidation of the Central and Northern Divisions (April 1, 1921). The name of this unit, the Liaison Staff of the Central Division, clearly defines and describes its functions, for it is a medium for relaying information from the men in their homes to the central authorities of the government and of bringing the services of the government to the home communities. The office of the Liaison Staff is located in Minneapolis, that its work may be closely coördinated with that of the district offices of the government bureaus entrusted with the administration of the War Risk Insurance and Federal Rehabilitation Acts—namely, the Bureau of War Risk Insurance, the Rehabilitation Division of the Federal Board for Vocational Education, and the United States Public Health Service—which are located there. Its special task is to facilitate communication between the home centers of the patients and these government agencies, in order to effect individual adjustments.

On this Liaison Staff there are three individuals in charge of the work for disabled men who need general medical attention throughout these four states. Since October 20, 1920, one worker has had charge of the correspondence concerning men suffering from mental and nervous disabilities and has been assisted part of the time by a student, doing practice work under supervision.[1] The work of the department here described includes only the neuropsychiatric problems, although the work with general medical cases is largely of the same nature.

According to acts of Congress passed October 6, 1917, all men who served in the United States Army or Navy after

encouragement, legal, medical, and business advice, and other service, when acceptable and necessary, in like manner as is now being done for the families of men at the front.—Curtis E. Lakeman, in *Home Service and the Disabled Soldier or Sailor.* American Red Cross, 210, August 15, 1918. pp. 16-17.

[1] A survey of the neuropsychiatric social problems in the Northern Division was made by a psychiatric social worker, beginning July, 1920, and the work of the psychiatric case correspondent may be said to have been begun as a part of the survey. The work done during the survey will be included in the description of the regular work of the correspondent.

April 6, 1917, and who either incurred disabilities from such service, or suffered an aggravation of disabilities existing at the time of enlistment or induction, are entitled to examination, hospitalization, and treatment by governmental medical authorities, to monetary compensation, and to reëducation for the purpose of adapting them to their handicaps. The administration of these acts was provided for through the Bureau of War Risk Insurance, the Federal Board for Vocational Education, and the United States Public Health Service.[1]

Theoretically, with this provision for organization, men who needed the benefits of these acts could communicate directly with the bureaus and receive proper attention for their claims. But the volume of applications was so large that these organizations were unable to perform their newly instituted functions smoothly and justly without breakdowns. There were delays, de-personalization, and a not infallible weighing of merits. Even if an ex-soldier did present his claim directly to the proper authorities and in the proper form, there were often errors and delays that deprived him of needed treatment or left him to suffer want or idleness while awaiting a deferred decision from one of the three governmental agencies.[2]

Since the applicants are scattered so widely, there have been demands for expert help in filing and prosecuting claims in every community, even the smallest. In all but the most thickly populated sections, there is not enough work in one accessible group to keep a worker busy all the time. In consequence, a large volume of business is carried on by volunteer

[1] By action of Congress, August 9, 1921, a new agency known as the Veterans' Bureau was created to take over the functions of the Bureau of War Risk Insurance and the Rehabilitation Division of the Board of Vocational Education, and the activities of the Public Health Service relating to ex-service men, with the exception of the conduct of such hospitals and dispensaries as are operated by that service.

[2] This was expressed in an explanation of the needs of Red Cross Home Service, after the cessation of hostilities and the return of most of the men to civilian life, as follows: "To put their claims before the government in convincing form is growing more and more difficult as the time since their discharge grows longer. It is no easy task to secure evidence and affidavits which such men must have in order to claim the compensation that is their right, if their disabilities can be traced to service." New England Division *Bulletin*, American Red Cross, Vol. V. February, 1921. p. 2.

and half-time workers in the local Home Service sections of the Red Cross, who, of course, cannot be as expertly informed as a worker on a full-time basis. Even if these local volunteer workers were well posted and skilled, the already over-taxed organization in Washington (Bureau of War Risk Insurance) would be still further burdened if it were transacting business directly with all the small Home Service chapters concerning claims, as well as with all the men who were able to attend to their own claims. Manifestly, utilization of district units decreases the pressure of work in the central office of the Washington bureau by sifting and clearing cases and by doing away, as far as possible, with the sporadic, futile procedures of those who do not know the complexities of the organization. It is at the division office, therefore, that case correspondence justifies itself. It may be compared to the long-distance telephone operator who receives a call from one local point to be connected with another point and who responds efficiently, since it is her function to coördinate the various lines properly. It would be impossible for the telephone company to connect each large city—to say nothing of every hamlet and village—directly with Washington; and it would be proportionately as complicated for every man and every local community to correspond directly with the rehabilitation bureaus in Washington in regard to each point of a claim or upon other matters of a personal or individual nature.

Expediency alone, however, is not a sufficient justification of the case-correspondence method, for the government is under an obligation to its ex-service men because of certain sacrifices exacted of them which cannot be compensated for by making the easiest means of remittance the only consideration. These sacrifices, although they have accumulated in great numbers, are not alike in origin or nature, and therefore cannot be treated alike, even though they sprang from the necessities of the same situation. Since the men who underwent the strains of war had had such different pre-war experiences and preparations, they naturally reacted in a variety of ways. In some, the reactions produced immediate collapse; in others, a more or less prolonged self-control or repression, resulting in a deferred disintegration of intellectual capacities or emotional

stability. Thus, in order to bring them back to a normal condition of health and social efficiency, it is necessary to treat them as individuals and to consider their differences in intelligence, heritage of health, family tradition, and social status. Acts of legislation for war rehabilitation must function through individual adjustments, like any other legislation of social import. To bring this about is the task of the social worker, and when questions of personality, behavior, and mental health are directly involved, it is the task of the psychiatric social worker. As there are not enough psychiatric social workers to equip adequately existing clinics and health agencies, it is obviously impossible to furnish one to every community that has a problem of an ex-soldier disabled mentally or nervously. Those who are available for this work of rehabilitation can, therefore, be best utilized by placing them in district or division offices, to initiate and forward communications between the local communities that cannot be visited in person and the neuropsychiatrists who need information from them.

In considering the duties of the psychiatric social worker in the correspondence section of a division office of the Red Cross, one may use, as a basis for discussion, the functions of these workers as formulated by "a conference of those engaged in the training of psychiatric social workers and those interested in the services of such workers".[1] The function of the psychiatric social worker was generally defined as one of "assistance to and coöperation with the physician in restoring the patient to health and social adjustment". The worker in the liaison office above described had not only to help the physicians of the United States Public Health Service in treating the patients, but also in detecting patients who needed such treatment, in persuading them to seek and accept treatment and adjustment, and in referring them to the government agencies in order that they might be eligible for treatment.

Specifically the functions of the psychiatric social worker, as defined by the conference, are: "(1) to facilitate admission to hospital or clinic and to facilitate continuance of treat-

[1] See *Function and Training of the Psychiatric Social Worker.* MENTAL HYGIENE, Vol. V, pp. 434-5, April, 1921.

ment by removing personal and family prejudices in regard to treatment; (2) to bring to the physician personal and social data helpful in arriving at a diagnosis and in outlining treatment; (3) to assist in carrying out the treatment advised; (4) to interpret the function of the hospital or clinic to the patient, the family, and such community organizations as are interested in the patient; (5) to undertake social investigations that will contribute to medico-social research". These specific functions will be taken up in the order given and applied to the activities of the psychiatric social worker doing case correspondence.

1. Some of the difficulties frequently encountered in fulfilling the first function—"to facilitate admission to hospital or clinic and to facilitate continuance of treatment by removing personal and family prejudices in regard to treatment"—are obviated by the resources of the United States Public Health Service. Its hospitals are not differentiated in the public mind into general medical, tuberculosis, and "insane" hospitals as rigidly as they are in the case of hospitals for civilian patients, and are not encumbered with such labels as "lunatic asylum" or "institution for the insane", bearing an affective tone of disgrace. Because of the large number of disabled soldiers, the government has seen fit to treat some of them as "contract" patients in state hospitals. In such cases, the objections of family and friends are frequently obviated by their feeling that the patient's disability is due to his sacrifices during the war. They think of his illness as "shell shock"—a more acceptable term to the lay mind than "insanity", with its ugly connotations. The heroism of his war service mitigates the feeling of shame that might have been present if he had been a civilian patient and had just "gone crazy". Nevertheless, the need continually arises of overcoming the objections of the family to hospital treatment, especially when, because of lack of adequate facilities in the hospitals of the United States Public Health Service or the social expediency of commitment, it involves treatment in a state hospital.

The method used in meeting these objections has consisted chiefly in drawing repeated analogies between the mental ailment and a distinctly physical disability. The local Home

Service secretary, who, in turn, passes on this point of view to the family, is reminded that if John Jones' leg had been shattered and infected in shell fire, his people would not feel disgraced about his going to a hospital. The point is then made that the mental disability is just as much an illness as the shattered leg; and that the hospital for the mentally ill ex-soldier is just as reputable as the hospital for the soldier who has lost a leg or has incurred other physical disabilities. This method of persuasion is preferred and is used except in cases of last resort. The incentive to regain health and earning power is also emphasized. If the patient or his family continues to refuse hospitalization or other advised treatment, in spite of attempts at persuasion, and the delay is harming the man and his immediate social group, the appeal may be to an economic motive, if there is any financial need. (The Bureau of War Risk Insurance refuses to continue payments of compensation if a man fails to accept available care or refuses to utilize all the resources for the diagnosis and treatment of his disability.) This latter argument may prove effective in securing immediate treatment for a particular patient. If, however, the family in the end still feel disgraced or manifest a disapproval of the patient, the worker should feel that she has failed, since she has not been able to make sufficiently clear to them the nature of the disorder from which this patient is suffering.[1] In handling a correspondence case, it is necessary to keep in mind not only the immediate needs of the patient, but also the future attitude and adjustment of the patient's family and the point of view of the community to which it is hoped he will return. The policy is not to look upon any case as an isolated task—merely the problem of putting John Jones into a hospital—but as a means of introducing the average lay citizen to a better understanding of the problem of hygiene involved.

2. The second function of the psychiatric social worker—

[1] An ideal can be applied here that is part of good social work and that has been expressed in regard to the spirit of Home Service as follows: "The truant officer's success depends not merely upon the number of pupils whom he has returned to school, but in the number of parents who, through his efforts, have been made to realize the importance of education for their sons and daughters." Porter R. Lee and Karl de Schweinitz. *Home Service*, American Red Cross, 200, July 16, 1917. p. 71.

"to bring to the physician personal and social data helpful in arriving at a diagnosis and in outlining treatment"—covers the bulk of the work of correspondence on mental and nervous cases. In coöperating with the government agencies, the worker has to aid in the making of three types of diagnosis, two of them depending upon the medical diagnosis, which is major in importance. These are: the type of illness (medical diagnosis proper), compensability (relation of disability to the applicant's war experiences), and the decision as to whether or not it is expedient to try to improve the applicant's condition and status by vocational training. Thus, a history is valuable not only for the use of the examining physician, to enable him to tell the patient what is the matter with him, but for the Bureau of War Risk Insurance, in order that the patient's condition may be understood fairly and adequately, and for the Federal Board for Vocational Education, to use in suitable placement for training.

Whenever there is doubt as to the nature of the patient's disability or whenever he is to be reëxamined or sent to a hospital, an attempt is made to obtain as complete a history as possible. This history contains data significant to an understanding of the physical and mental make-up of the patient and includes such items as the health and social situation of his immediate family, his developmental history, his previous illnesses, his school progress, his occupational record, his character traits and habitual reactions to people and situations, and the details of his military experiences.

The Bureau of War Risk Insurance determines the degree of a man's compensability largely from a comparison of his economic efficiency since discharge with his efficiency prior to enlistment; hence it is highly important to get the details of the patient's economic history fully, specifically, and accurately. Since this is such a decisive point in regard to compensation and eligibility for treatment, it is secured in the form of affidavits. Even when letters containing most specific directions are sent to Home Service workers, asking them to secure information from former employers for affidavits, the results are often too indefinite to be satisfactory. The Bureau of War Risk Insurance provides blanks, therefore, for such affidavits, but those blanks were not prepared

with the ex-soldier suffering from nervous or mental disease in mind, as they did not ask for information that would bring out the salient points in the development of a nervous or mental disability. For this reason, a special affidavit form was devised and used in cases in which the ordinary form or detailed instructions would not bring results. This special form sought to obtain not only dates of employment and salary scales, but the relationships of the patient to his fellow employees and his employer, the degree of interest that he showed in his work, and other phases of personality that might reveal themselves in employment. The methods of obtaining the full histories will be described in greater detail later. This history is doubly important since it is necessary to establish any connection there may be between a man's disability and his service experiences. After a patient's eligibility for governmental consideration was established, his history was valuable, not only for medical purposes in the hospital and clinic, but also for the purpose of determining the most effective type of vocational training to give him. Therefore, a copy of an applicant's history was sent to the United States Public Health Service, the Bureau of War Risk Insurance, and the Federal Board for Vocational Education.

3. The third function—to "assist in carrying out the treatment advised"—has not been fulfilled to any extent. Men were discharged from the army at such a rapid rate that those who were still disabled were not all referred properly for after care, so there were no adequate records of the men who were in need of treatment and compensation. Large numbers of these disabled soldiers did not even know of the benefits in the way of treatment, compensation, and reëducation that were available for them. Others would have been unable to prosecute their claims had it not been for the help of the social worker. The pressure of this work of recording the claims of disabled men not yet treated or compensated has been such that more attention has been paid to it than to men who have been awarded compensation and who have had hospitalization. In general, this is not a wise policy to pursue, for it is considered better to treat a few cases thoroughly than to give a little attention to many cases. However, under present conditions, it becomes increasingly difficult for men to receive

favorable attention to their claims with the passage of time since their discharge from the army. In view of the lack of facilities in all but the large cities, ideal social treatment could not be given even if the work were restricted to a very few cases; and such a method would, possibly, deprive all but a very few of any benefits at all. Neglect of some cases would be considered discrimination and would provoke cynicism with regard to the government and skepticism with regard to social work. On the other hand, the American Red Cross can arouse an appreciation of social work throughout the community at large if it proves of benefit to the majority of its clientele.

Because of the scarcity of centers of medical treatment, emphasis is placed on keeping the patient near to one until he has recovered or is satisfactorily improved. In cases where it is felt that supervision should follow in the community, such supervision can be encouraged and promoted by the case correspondent in the division office by sending to the local Home Service secretary articles and pamphlets upon the subject in hand. The local secretary's interest in following the case is stimulated by frequent letters asking pointed questions, the answers to which she will have to obtain by noticing the patient's behavior and social situation closely. Then can follow discussion and advice as to meeting situations and utilizing the observations she has made. It is desirable to cover, in after-care treatment, the various phases of the patient's life, not only for his own welfare, but for the educational value it has to the local Home Service secretary in familiarizing her with the thoroughgoing routine of social case work. Treatment letters, as such, require more tact than those requesting histories. The latter can be linked up with the necessity of a man's getting compensation and thus seem, even to the most amateur Home Service secretary, to have some utilitarian value. After such obvious details have been attended to, unless the necessity of follow-up work be pointed out skillfully and the work involved be taken up specifically, the Home Service secretary is inclined to think of the correspondent as a theorist enjoying the luxuries of a swivel-chair position. There are some who cling to this idea, and it prevents the possibility of responsive coöperation between the case correspondent and the Home Service secretary. In the

matter of treatment, however, the psychiatric case correspondent has had to be content with the most obvious details, and even these in only a minority of the cases, for on the whole this function has not developed as fully as has that of securing data.[1]

4. The fourth function—"to interpret the function of the hospital or clinic to the patient, the family, and such community organizations as are interested in the patient"—can most readily be performed by the social worker on duty in the hospital. It is part of her work to write letters from time to time to the family of the patient, explaining the situation and the hospital life of the patient. Copies of these letters usually do, and should, pass through the case correspondent's hands at the division office, that she may see that they are adapted to the community to which they are to be forwarded and make sure that other matters of importance to the case as a whole are not neglected. In many instances, it seems more desirable for the correspondent to gather the facts from the hospital and then to write the letter directly to the community through the Home Service secretary. It is sometimes difficult for the worker in the hospital to free herself from the technical and scientific atmosphere of the hospital and to adopt a simple, lay style that is comprehensible to a worker in a small community. The case correspondent tries to incorporate the professional reports of the hospital in matters of local interest and to write in a colloquial style, to help the family realize that the patient is not in some strange and unusual and, possibly, dreadful environment about which they can know nothing.

5. To the fifth function—"to undertake social investigations that will contribute to medico-social research"—which involves the broader aspects of the work, this department may contribute an initial survey. A survey of the division is being made to discover ex-soldiers who need medical advice, in order that they may be brought to the attention of the governmental bureaus responsible for their care. The results of this survey will have considerable social value, but its effects will exceed its immediate purpose. To make the Home Service secretary of each community aware of the soldier disabled mentally or

[1]For a "treatment" letter see pp. 152-54.

nervously, to cause her to be on the look-out for him, to realize his needs, to be optimistic of his future under proper care and supervision, is to arouse an interest that, while centered for the present on the problem of the soldier, will eventually flow into the larger community problem, and she will soon be as aware of civilian patients and their possibilities as of soldiers. Case correspondence throughout the year with the local Home Service secretaries—a correspondence in which the possibility and necessity of early care of the ex-soldier disabled mentally or nervously is being constantly emphasized, in which inquiries are continually being made in regard to the details of a patient's childhood and adolescence—must have a very definite mental-hygiene value. Gradually the importance and significance of these things are borne in upon the local secretaries, their assistants and chapter workers, and a new sentiment and a new point of view find their way into the community. If John Jones, who was decidedly "queer" when he returned from France, but who, having been treated in a government hospital, is now back in the community with the word, and manifesting, that he is recovered, can be helped in taking up again his community life and in remaining well by following out certain suggestions made by the case correspondent, then similar assistance ought to be helpful to John Smith, who has recently returned recovered from the state hospital; if early treatment offered hope to Bill Brown, the ex-soldier, probably early treatment would have possibilities for Bill Smith, his civilian neighbor; if the seclusiveness during adolescence of Tom Williams was of such significance in his later life, probably the seclusiveness of Tom Martin, now in the high school, is important. This penetration of the community has its importance for social case work as well as for mental hygiene.[1]

[1] The following statements as to the opportunities of the Red Cross in its Home Service work may be of interest:

"The opportunity is great not only because of the newer and larger group of people whom it reaches, but because of the tremendous extent of the work. Home Service, with its gospel of the case-work method, is reaching not only the large towns and cities, where it is striking because of the new group of families which are being served in this way; it is reaching also the hundreds and thousands of small towns, villages, and countrysides where the county poorhouse or the undirected effort of church or neighbor to bring a little relief to the utterly destitute have been heretofore the only social agencies known.

In addition to the functions falling under these five categories, special activities have arisen. For instance, the rural community and home of the patient must be interpreted to the three government bureaus.

The case-correspondence department secures its cases from the following sources: (1) through workers doing case correspondence on general medical cases; (2) through the chief psychiatric social worker of the division; (3) through the records of applications for compensation in the Bureau of War Risk Insurance office, investigation being made of those that claim mental or nervous disability; (4) through requests from other division headquarters and hospital workers for information concerning men whose families live within our jurisdiction; (5) through requests from the neuropsychiatrist of the district office of the Bureau of War Risk Insurance for information and help in obtaining affidavits; (6) through information volunteered from the Home Service secretary; (7) through information from field representatives; and (8) from miscellaneous sources.

When the work was first organized, cases were secured from the first source. Since then, whenever any information comes in on a case that has been referred to the general medical workers that bears evidence of a possible mental or nervous disorder, it is transferred to the psychiatric social

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"The fact that it is so easy to demonstrate that Home Service does not fall under the head of *charity*, as the word is understood by the average individual, gives a great educational opportunity. Little by little, as people come to see the ideals of constructive helpfulness which are a part of the Home Service work, they will come also to see, with a little suggestion on our part, that these ideals are not confined to work with soldiers' families—that they are the only true way of helping any family in difficulty." Agnes L. Murray, in *Case Work Above the Poverty Line.* Proceedings of the National Conference of Social Work, Kansas City, 1918. pp. 342-343.

"I believe that the Home Service work which the American Red Cross conducted during the war among soldiers' and sailors' families in every town and hamlet in the country has done more than any other movement at this time toward developing in country folk a sense of responsibility for their neighbors; of awakening in them a social consciousness that is calling forth, rather than repressing, local social needs. . . . The future of family social work, therefore, lies largely with the individual worker, who is going to present it to the rural districts, and there lies the problem." Henrietta J. Lund, in *Case Work as Applied to Rural Communities.* Proceedings of the National Conference of Social Work, Atlantic City, 1920. p. 296.

worker. Complaints of "dizziness", "nervousness", "nervous breakdown", inability to work steadily, "loss of memory", "fainting spells", "shell shock", "excessive irritability", and extreme worry, appearing in the report of the preliminary physical examination that accompanies the claim of the ex-soldier, are considered to warrant further investigation; and the cases in which they appear are taken over by the psychiatric social worker. The same applies to cases of men who have been committed to state hospitals or who have already been diagnosed as mentally or nervously ill. Cases in which problems of delinquency appear are often referred by the general workers, since they are considered problems of behavior and personality.

If a man comes to the clinic of the district office of the Bureau of War Risk Insurance for an examination, and the general examiner refers him to the neuropsychiatrist, he is interviewed by the chief psychiatric social worker, who takes as complete a psychiatric and social history as it is possible to elicit.[1] This history is then placed in the hands of the neuropsychiatrist at the time he examines the patient; after the examination, the diagnosis and recommendations are given to the social worker. In the case of a man not living in Minneapolis or St. Paul, she gives a copy of this history, together with the recommendations and remarks of the neuropsychiatrist, to the psychiatric social case correspondent. These diagnoses, histories, and recommendations sometimes concern men already known to the worker and serve as supplementary information. Frequently they serve as the initial contact with the man and are very valuable as a basis for the initial letter to the Home Service secretary in the patient's community. From this material a judgment can be made of the most important additional information to ask for in the letter. Enough information is given to the Home Service secretary to enable her to take up the case with some understanding, although, according to a ruling of the United States Public Health Service, diagnoses are never given to the chapter.

A carbon copy of the preliminary physical examination of an applicant for compensation is sent to the correspondence

[1] For a description of this work, see *The Personal Psychiatric History*, by Lila Kline, pp. 93-124 of this number of MENTAL HYGIENE.

section, as a matter of routine. This contains a brief account of the patient's symptoms, the clinical findings, the military history, and the preliminary diagnosis. If the diagnosis is of a mental or nervous condition, the copy of the examination is assigned directly to the psychiatric correspondent. Suggestive symptoms in the complaint are usually not sifted out until the general medical correspondents read them, for the clerical staff does not attempt to detect such matters. On these cases, a letter is sent to the Home Service secretary stating that the patient in question has applied for compensation and treatment and describing in general his ailment. It is explained that he will probably have difficulty in establishing his eligibility for training, and that social data concerning him will be a valuable assistance to him. Furthermore, it will enable the physicians at the district office of the Bureau of War Risk Insurance to determine more exactly what is the matter with him and what type of treatment will be of most benefit. The question is also asked whether the patient is willing to accept hospital care and whether he is free to do so or whether there is any social or financial difficulty that would prevent his doing so. The Home Service secretary is advised that, in case there should be some such difficulty, it would be well to ascertain the resources of the family and to help them to adjust matters, emphasis being laid upon the fact that the Home Service chapter has a responsibility in this regard. All such possibilities are preferably handled in the first letter, since the Home Service secretary may have to travel to some community difficult of access to obtain the desired information, and she can afford neither the time nor the money to make several trips to cover points that can, with planning beforehand, be mentioned in the first letter and covered in one visit. With the exception of the few city populations in the district, the counties, the units of Home Service work, cover large areas which are not furnished with efficient train service, so that it may take a worker two or three days to cover a case that could have been handled in a city in a few hours. This is mentioned here since it applies especially to cases concerning which nothing is known except the brief information in this preliminary examination. Where information is already on file at the time the case is referred

to the psychiatric social worker in the correspondence office, the amount of ground it is necessary to cover in the first letter can be more accurately determined, but as a general rule, the first letter on a case must cover as many contingencies as possible. Of course, this does not apply if the Home Service secretary's office is in the man's home town. Replies received to letters written on cases begun in this way sometimes do not justify further continuance of the case, but they serve as a sifting process by means of which the cases that do demand more intensive investigation and treatment can be more readily discerned.

There has been considerable difficulty in settling many claims properly as a result of the fact that the men have been drifting about more or less since discharge, not staying in one part of the country long enough to have their claims properly attended to. No sooner are Red Cross activities started in their behalf in one division than they move on to another. By communication between the division correspondence offices, services analagous to those of a confidential exchange are obtained. If a man's present home is in one division and information is needed from his previous address in another division, this is asked for through that other division. Requests from one division to another are made in duplicate, so that if the recipient thinks the letter adapted to the Home Service secretary for whom it is intended, she can forward it without any changes. This is a desirable method of saving time if the possibility of a good result is not sacrificed. The Home Service secretary is asked to send her reply in duplicate through the correspondence office, that the files on cases may be kept complete. Close coöperation between the division offices is a partial solution of the problem of transient applicants. It enables follow-up work and social treatment to be carried on in cases discharged from hospitals far distant from the patient's home.

The technique and routine of the psychiatric social worker in the correspondence department, in handling and recording cases, are simple because of the volume of work. At the time a case is referred to the psychiatric correspondent, a letter is dictated upon it covering the present needs. The nature of this letter depends upon whether it is a new case or one upon

which information has already been obtained. An index card is made for the case which contains the patient's name, his address, the name and address of his nearest relative, dates of hospitalization, and a statement whether compensation has been awarded, and whether or not a guardian has been appointed. From time to time the worker jots down in pencil any details that may be of significance and that will enable her to construct a picture of the case immediately, without the correspondence file. The diagnosis and any severe social symptoms or other matters that should be taken up are eventually entered upon this card, also. The card is then placed in a file that is kept on the desk of the correspondent. At the same time another card is made for the follow-up file, upon which is entered the name of the patient. This is placed in a "tickler". If a reply has not been received by the time the card appears in the "tickler", a follow-up letter is written. Carbons of letters dictated and the replies received are kept together in chronological order and filed with the other correspondence cases in the record department of the office. If a record is voluminous and complicated, a memorandum is also kept with it so that in a moment's glance one can detect the present situation and tell what more is to be done. In analyzing the problems of a case in a rough way, Dr. Southard's classification is being more and more widely used: disease, (*morbi*); ignorance, (*errores*); bad habits, (*vitia*); legal entanglements, (*litigia*); poverty and resourcelessness, (*penuriæ*).[1] The factors of disorder in a particular case can be arranged according to this grouping on one side of a sheet of paper, and in a column parallel with it the methods that can be utilized for correcting them. Then, as these things are done, a check can be made, so that at a glance one can tell what has been accomplished and what there is still to do.

Another file is kept on the correspondent's desk. It contains the names of the Home Service secretaries with whom she has cases. This file is arranged according to Home Service chapters. The name of the chapter secretary is placed upon this card and also any significant characteristics that

[1] Southard E. E. *The Kingdom of Evil; Advantages of an Orderly Approach in Social Case Analysis.* Proceedings of the National Conference of Social Work, Kansas City, 1918. pp. 334-40.

may have been gleaned from correspondence and from other sources, such as reports of the field representatives of the Red Cross. Notes are jotted down which indicate whether the secretary is prompt in replying or not and whether he or she is interested in the work and grasps the meaning of what is wanted. Information as to the manner in which a particular secretary may best be approached and similar items are valuable and should be easily accessible as aids in shaping the letter in such a way as to bring the best possible response. On the back of this index card are recorded the names of the cases located in the county. This enables the psychiatric case correspondent to keep clearly in mind all the work she is handling with one secretary. When a field representative, therefore, announces that she is going to a certain county, it is easy to ascertain at once what cases are being handled in that county on which correspondence is lax, and in regard to which it is advisable to have a special conference or investigation such as the field representative can give upon her visit.

The activities of the field representative are valuable to the case correspondent because, if there is a "dead" chapter or a correspondent who procrastinates on an urgent case, the field representative can give a more forceful follow-up contact in person. She can, also, in her talks to the chapter executive committee, emphasize the desires and plans of the psychiatric correspondent and give an additional stimulus to the work. However, the field representative is used as a last resort, since she has other things to do and cannot devote all of her time to the needs of the correspondence department. A chapter may go several months without a visit from the field representative, so that if the chapter is slack in its methods, cases will suffer unless the most skillful tactics are used in the liaison office.

During the first few months of this psychiatric case correspondence work, histories were obtained in two ways: (1) by sending a short letter of explanation with an outline;[1] (2) by giving in detail in the letter questions concerning the points

[1] This outline is given in Appendix I. The four appendices to this article have been omitted here from lack of space, but will be issued with the reprints of the article.

of information most needed. There are advantages and objections to both methods; neither is quite satisfactory.

Time-saving is the chief asset of the first method. A copy of an outline can be sent with a short letter, half a page in length. This is an especially important factor where the volume of work is large, as it is in the Minneapolis office, where at the present time there are two thousand cases either being handled by the psychiatric social worker or in need of her attention. All of these cannot be handled adequately, but the number of those that can is increased by the use of a device such as the outline. An obvious concomitant of the time saved is financial economy, which should be considered in the dispensing of a trust fund[1] such as that of the Red Cross. In addition, it is a saving to the recipient of the request in the Home Service chapter, since she soon becomes familiar with just what is wanted in each case. Furthermore, the outline tends to give a more standardized reply from the point of view of form as well as content. Its use in the securing of histories, which absorbs so much attention, leaves more of the psychiatric case correspondent's energy for problems of treatment, which have been touched upon only scantily in the work so far.

But there are disadvantages. The use of the outline diminishes the possibilities of giving each case human, individual interest. It favors routine in work instead of the individualization that is so necessary in social case work. The psychological effect on the person dictating is bad, for if she resorts to an outline for part of her work, she will be inclined to resort to stereotyped methods in other phases of her work. The outline that has been in use is too likely to fill the Home Service secretary with "awe", to seem to her a forbidding thing. In one case it frightened her; she thought that the patient in question must be at the point of death to have such an array of questions asked concerning him. The formality of its style is connected in the worker's mind with the mysteries of the doctor's office. In fact, the worker is sometimes confused as to the exact nature of the information the psychiatric case correspondent wants, goes to the local doctor

[1] Lecture of Mr. Robert W. Kelso, Smith College Training School for Social Work, 1921.

who has examined the patient, and gets his bare medical report. In spite of directions to the contrary in the letter of explanation that accompanies the outline, the result is generally that the outline is considered a questionnaire and is filled out accordingly. This means that only the briefest of answers are given, such as "yes" and "no" or ambiguous figures. The result is a static, colorless thing, whereas what is wanted is a graphic picture of the *life* of the patient. The outline is too technical for many of the Home Service secretaries who happen to be housewives, bankers, grocerymen, or who are chosen because of their popularity in their small communities. To many of these people, one has a mental disease if one is "crazy" and has been sent to the "lunatic asylum" or one has had a nervous disease if one has had "nervous prostration". Therefore, it is more than likely that if the question is asked whether there has been a nervous or mental disease in a man's family the answer will be "no", unless such a disease comes within the category of "craziness" or "nervous prostration". The same is true of other topics covered in the outline. In short, the use of the outline is as handicapping in social work as is the circular letter in business.

The individualized type of letter, on the other hand, is a method of attacking each case with unique interest and as if it were of the utmost importance. It, therefore, can give the Home Service secretary a fresh view of each case she handles. It enables the case correspondent to mold her questions to fit possible social exigencies. It puts in a personal appeal that enables one to get one's idea forcibly into the Home Service chapter's ambitions and program for work. In addition to individualizing the patient, it also individualizes the Home Service secretary who receives the letter. Professional jargon and technical style are bound to creep into the outline; whereas the individualized letter is better adapted to a lay style and can be written in a "folksy" manner.

But unless the individualized letter is really dictated in this freshness of interest, it, too, will become a veritable outline. It often so results if it is made up of an array of questions. This is brought to the attention of the psychiatric case correspondent by the fact that the answers come back in brief forms

such as "yes" or "no", inserted between the lines of the letter or in the margin. Another serious difficulty in the use of the individualized letter is that it takes so much time in dictating. It also makes a very long letter for the Home Service correspondent to read. This matter must be taken into consideration, for the Home Service secretary, too, is busy, and voluminous letters have a tendency to be annoying.

In order to obtain the opinions of the Home Service secretaries concerning the work on these cases and the methods of which they approved, a questionnaire was sent out to forty-eight of them who had had opportunity to become somewhat familiar with the work. Only fifteen of these returned replies so that no definite conclusions can be drawn, but a summary of the answers is interesting:

> Question I: When it is necessary for you to obtain information for a social history, do you prefer to receive a letter with detailed questions and instructions upon which to base your investigation or do you find a short letter with one of our form outlines more convenient?

Of the fifteen who replied, four preferred to work with an individualized letter as a basis, one stating, "A letter with detailed questions . . . seems to have more of a personal touch—which is so essential in these cases". Ten preferred the outline with the short letter, one adding, "especially if any special features of the case are explained in the letter"; and one, "if it is an entirely new case". The fifteenth stated that it made no difference which method was used.

> Question II: Have our services been of use to you in securing treatment for these patients and, if so, what activity of ours has been most effective?

Of the fifteen, eight stated that they had found the services useful. One wrote: "Yes. Your follow-ups of cases aid us to get information about them which we frequently cannot get in any other way. From Red Cross reports we sometimes find that men in our own vicinity need assistance when we had been ignorant of the fact. Your close coöperation with Legion officials is also of much assistance to them, particularly in our case here"; and another: "Your most effective activity has been in rushing cases long delayed, and especially those emergency cases needing immediate treatment, by accepting

our statements by wire, and getting transportation rushed to the man or hospital authorization granted. . . . We have never secured treatment for patients in any other way except through your office, so there is no question as to whether you have been of use in this respect."

One did not answer the question at all, and three returned indefinite answers. Two had not referred any cases, and one stated that she was unable to answer the question intelligently as she had not been able to secure prompt treatment for any of her cases but one.

Question III. Have our requests seemed reasonable and is explanation full enough?

Twelve answered this question in the affirmative; one did not answer it at all; and two returned indefinite answers, one stating that she was not certain whether it was advisable to annoy the relatives of ex-service men by trying to secure the entire family history, unless there was "a reasonable possibility of something to be gained by it".

Question IV: Have you any criticism to offer concerning the contact we have had so far with you on these problems or have you any suggestions to make of improvements in our work which would be more convenient for you?

Eight answered both parts of this question in the negative, one adding: "Am always glad of suggestions and advice from Liaison Office, especially with mental cases, as the experience of people who make a specialty of this type of case is invaluable." Four had no criticism to make, but offered suggestions. One of these wrote: "We find that the greatest problem confronting us at the present time in connection with these cases is the requirement of the Medical Division of the Bureau of War Risk Insurance, to secure additional medical evidence to establish connection between the present disability of these former service men with their military service"; another: "I would suggest that a list of all ex-soldiers, suffering from 'shell shock'—nervous breakdown—in this county be furnished us so that we will know just who they are, to assist us in our care of said soldiers"; and another: "I have no criticism to offer concerning your contact, but

suggest that there should be more individual and detail work done when the man is sent into Minneapolis for examination." One did not answer, and two made criticisms. One of them wrote: "My criticism would be that after a man comes to our notice and is in immediate need of attention, so much time has to elapse before we can find out what may be done for him that usually the strain of waiting for information is too much for him and he suffers a total breakdown, as in the case of two of my subjects"; and the other, "The contact has been nothing but advantageous. The only criticism we might offer would be that it is sometimes very irritating to have data information asked for that has already been sent to the office at some previous time. All Home Service sections have a few aggravated cases that regular routine seems impossible to adjust. Might we not work out some more advantageous plan for such cases? I think it was this fact that made the state Legion want to take over some of the work. We have never felt it useless to write your office on any subject for information or aid."

Field representatives say that the most frequent criticism they hear of the work of the department is that it is a nuisance created by some one sitting in an office who does not realize the difficulties and the pressure of rural work. This criticism does not come from all the correspondents, but from enough to make it necessary for the psychiatric case correspondent to weigh her problems carefully in order not to ask for details not absolutely essential. In seeking information, questions must be so formulated as to show their specific relation to the patient's problem; otherwise they will seem irrelevant and inconsequential.

In order to meet the objections to the outline method of obtaining histories and to preserve its time-saving advantage —as well as the benefits of the individualized letter—a new type of letter was devised. It is constructed on the principle of the form letter. It provides for an initial paragraph which will be individual in every case and will explain the particular situation involved. Several form paragraphs have been written, covering the chief points that are brought up in request-

ing histories.[1] It was found desirable not to have the paragraph filled with questions. When many questions are asked, although they may cover most points, they do not cover all points; and the informant, thinking that only those facts that are indicated by questions are wanted, does not volunteer other information.[2] Too many questions in a letter check a good response just as a stereotyped method of conducting first interviews may keep the person interviewed from giving facts that he would otherwise have volunteered. The object of this new type of letter is to avoid being mechanical and at the same time to cover as much ground as possible. Since, in some of the replies to the questionnaire, it was found that the Home Service secretary thought that the only information desired was a patient's statement or a medical record, an attempt has been made to frame the requests so that the secretary cannot fail to see the social implications in the patient's condition and will seek other sources of information. The danger in using the form paragraphs is, of course, similar to that in the use of the outline.

Another service that this department has tried to render the United States Public Health Service is in making more thorough investigations of cases in which the local medical examiner has not discovered sufficient corroborating evidence to substantiate the patient's complaint of an organic condition and therefore considers the applicant a whiner, or a malingerer in pursuit of undeserved compensation.

Theodore Solberg,[3] for example, in his preliminary examination for compensation, complained of a pain in the left calf and in the right arm. The local examiner diagnosed his condition as "chronic muscular rheumatism and probable chronic sacro-iliac rupture (on subjective symptom only)". Under

1 Form paragraphs for the social psychiatric history are given in Appendix II, for which see note p. 142.

2 "The logically arranged and categorically framed questions of an application blank suggest the answer that will lead to the decision desired by the applicant. This is the chief objection; another is that no formal set of questions, however full, can cover all possible contingencies; a blank may be carefully and accurately filled out by a witness and yet omit important items." Mary E. Richmond in *Social Diagnosis*. New York: Russell Sage Foundation, 1917. p. 319.

3 All the names of patients used in this paper are fictitious.

"Remarks", the doctor stated: "I do not believe that this man has an objective symptom. He works at his old trade as well as ever. I think perhaps part of his condition at least is feigned."

The following letter was written to the Home Service secretary:

> "The above-named man was examined by the United States Public Health Service representative in ———— on November 12, 1920. The doctor thought that there was nothing seriously the matter with Mr. Solberg, that his condition might be feigned. This impression of the doctor may be due to the fact that Mr. Solberg is suffering from some nervous or mental trouble or is unduly worried about his health. Will you please get in touch with Mr. Solberg and give him any after care that may be needed and find out how he is getting along at present?
>
> "Will you please get in touch with any relatives of Mr. Solberg residing in your county and obtain information as to his early history and family background? We are enclosing an outline which indicates the kind of information we should like to have you look for. This outline is not to be given to relatives to fill out as a questionnaire, but is only a guide to you in obtaining this information. We hope you can obtain this information for us as soon as possible, for then the United States Public Health Service will be able to determine more exactly the nature of Mr. Solberg's ailment and can give him better treatment. Please assure any one whom you interview that the information will be treated most confidentially and used for medical purposes only.
>
> "Will you also please find out when Mr. Solberg's claim for compensation was filed and whether he has received an award from the Bureau of War Risk Insurance? Is he interested in taking vocational training?"

This letter was not considered a good one by the psychiatric case correspondent because it did not give a full enough explanation to the secretary of the reason for obtaining the history. The case correspondent herself made a rapid association between a "feigned condition" and a possible neurosis, but she did not explain this clearly. However, as a result of the information obtained, the physicians were able to satisfy themselves as to the nature of the patient's complaint and he is now in hospital under treatment.

The following letter was the first contact between the psychiatric case correspondent and a Home Service secretary who had been trained in one of the Red Cross institutes for Home Service. She was interested in the work, had obtained valuable histories on many patients, and had done a great

deal of case work with mental patients, since she was situated in a county in which the Federal Board for Vocational Education had a training center.

> "Since in your letter you mentioned that Mr. Russell 'is very peculiar and hard to deal with and has been able to work only occasionally since discharge, and that he is an odd type', Miss Day turned him over to me, as you said that you sometimes fear mental trouble. It may be that this is a case in which the patient can be given proper treatment and a break avoided. Will you, therefore, get as complete a social history in regard to Mr. Russell as possible? We will submit this to Doctor Jones, the psychiatrist here, and see if he considers a special examination necessary.
>
> "Are there any peculiarities of behavior or personality, any moodiness or irritability, any unaccountable stupidity or irresponsibility? Any traits of this kind will be suggestive. Probably you have an outline on hand and no doubt you don't need one, but I am enclosing another of the lovely things. We will be tremendously interested in your report on this case, as of course it is preventive work that really counts."

The Home Service secretary in this case would have felt injured if the usual type of introductory letter had been written, considering the amount of work she had already done. Use of the index of correspondents enables the psychiatric case correspondent to keep constantly in mind the number of cases that have been handled by a secretary and thus to avoid ignoring her previous work.

Sometimes a chance phrase from a Home Service secretary may give a clue to some personality defect that may be at the root of an ex-soldier's disability. The general medical case correspondent then turns the case over to the psychiatric case correspondent, who investigates it more thoroughly.

The Home Service secretary in Mr. James' town wrote in about him with but thinly veiled exasperation, for he had been a most trying problem. She stated, among other complaints, that "at least he might wash his face" and in other ways intimated that he was indifferent and careless. This letter was written early in 1920. The case was inactive from then on and came to light again only when the present writer happened to find it as she was sorting some old cases. Some sort of follow-up letter was due with regard to Mr. James' compensation and present situation, and the psychiatric case correspondent wished to look further for the mental condition that she suspected. The following letter was written:

"The case of the above named man just happened to come to our attention. We notice that there has been previous correspondence with you in 1920 on this case. We were particularly interested in your statement that you were afraid that Mr. James was lazy and more shiftless than was necessary, and that he might at least wash his face and hands. He may not be suffering from any mental or nervous disability in the ordinary sense of the word. However, such characteristics as you have indicated are often signs of a mental or nervous ailment or of a personality that is not properly adjusted to normal social life. At any rate, a personality study of Mr. James would prove most valuable in understanding his case. It might be most beneficial to the United States Public Health Service in treating him.

"We do not mean to insinuate that every man who is careless about personal cleanliness and appearance is suffering from a mental disorder, for, of course, such is not the case; but it quite often happens if a man suddenly becomes careless about such matters or indifferent and lazy and absolutely lacking in ambition or energy, it is because he is very much discouraged about his possibilities in life or feels hopelessly depressed or bewildered and is therefore in a bad mental condition. A sudden change in such habits as have been mentioned is about as good a sign of some mental trouble as the onset of a cough is of tuberculous trouble. His listless attitude also may be due to discouragement on his part about his physical condition, and, if so, the same kind of understanding of his case would be valuable in the way of encouraging him and rehabilitating him. How is Mr. James getting along at present? Is he able to work any more than at the time of your last correspondence on the case? Has his claim for compensation been adjusted?

"We are enclosing another copy of our outline, which is used for a guide in making social investigation on mental and nervous patients. We should be particularly interested in any such points concerning Mr. James, and especially information as to whether he has always been careless and lazy or whether there has been some decided change in his personality and habits."

Although this letter would have been satisfactory if it were to have been sent to a secretary who was not familiar with the nature of the psychiatric case correspondent's requests, it was not used, since this particular Home Service secretary had given valuable aid on several cases of men suffering from mental and nervous disorders and was commendably interested in the subject. This is another instance of how a certain mode of approach would ignore the secretary's past work.

The following revised letter was sent:

"In going through the files the other day, I happened to notice the case of the above named man which has lain dormant for several months. I am very much interested in finding out whether you were able to persuade Mr. James to wash his face, or is his preference for dirt a confirmed habit of many years' standing? Has he always been careless

about his appearance and the impression he made upon his associates, or is that a recently developed characteristic?

"Is his compensation coming regularly and in sufficient quantities? Or has there been a hitch in this matter? Did he finally receive an award for vocational training? If so, do you think he was able to benefit by it?

"We are curious to know whether you think Mr. James has been suffering from some mental or nervous disorder or whether he was always a rather stupid, ineffectual person?[1]

"Is he able to work now and get along comfortably or is he continuing to be a hopeless problem?"

The second letter has the advantage of brevity. This is much to be desired when there is considerable pressure of work either in the central office or in the office of the Home Service secretary. Furthermore, a short letter, if not written at the expense of a lucid explanation, presents only a few questions which are, therefore, better kept in mind by the recipient.

The case of Harold Brown[2] illustrates many phases of the work of the psychiatric case correspondent. This patient had reported to the clinic of the district office of the United States Public Health Service. A preliminary neuropsychiatric history had been taken at that time. No indicative information had come to light in the interview, the patient complaining only of "nervousness" and a "breakdown" while in the service. His chief present worry was the fact that his mother had been appointed guardian over his property, and he was uneasy for fear that he would never regain his independence. A diagnosis of "manic-depressive psychosis, quiescent stage" was made. A letter was written to the Home Service secretary asking for a social history and emphasizing a desire for information regarding the mother's temperament. The contents of the reply indicated that the patient's disability had been more severe than he had mentioned in his interview and that he had had previous attacks. The information obtained was outlined and placed in orderly form to enable the busy doctor to read it more easily. The following "treatment" letter was then written to the Home Service secretary:

"You do not know how much we appreciate your letter of March 30 concerning the above named man; it gives so much of just the information we are desirous of having, especially on such things as the mother's

[1] Such a question is permissible only when the secretary is a trained worker.

[2] Given in Appendix IV, for which see note p. 142.

temperament and her probable influence over or attitude concerning her son and the kind of things that he likes and the things that bother him.

"In addition to concrete facts about a man's life for a psychiatric history, his attitude, likes and dislikes, hopes, worries, and fears are of the utmost importance in understanding his personality and its reactions.

"We are sorry that we failed to enclose the outline. We are sending it to you now in case you can obtain any further information for us. We are most interested in the mother, for influences of temperament and emotions are most often related between mother and son or father and daughter. The mother's personality is often a most important factor in the bringing-up and development of a child. If she is inclined to be highly excitable or to manifest nervous symptoms in any other way, her children are more apt to suffer the consequences in their bringing-up and to be more susceptible to nervous and mental breakdowns from time to time.

"We should appreciate it very much if you could tell us more of the home situation. Do you think the mother is an intelligent person who could be approached in a way to make her feel more hopeful about her son's condition and thereby decrease the amount of worry and nervous strain she imparts to him? Does she feel that his illness is a hopeless one and can never be thoroughly cured? Is she kind and sympathetic, or does she think his trouble is a disgrace and does she reproach him for it?

"We should like to have more statements from her as to how he had not been a normal child—whether it was due to a weak, sickly body or to difficulty in grasping situations and ideas. Was he irritable and quarrelsome as a child or friendly?

"We think that vocational training would be the best thing possible for Mr. Brown, since he is so anxious to take it and enhance his earning capacity. We have written to the Federal Board, urging them to get in touch with him and to award training in his case. The Federal Board has a specialist who confers with men who have suffered from mental and nervous troubles as to the best kind of courses to take. We have also written to the Bureau of War Risk Insurance as to whether Mr. Brown's compensation will continue if the guardian should be removed. Since Mr. Brown is so much improved, we think it would be perfectly possible to have this done by an application through the Winona courts, but we think it would be better to receive a reply from Washington.

"It is most important to see that every little matter such as this is adjusted as much as possible to relieve Mr. Brown from strain and worry and to prevent a further breakdown. He should be urged to lead a most regular, quiet life. You state that he becomes very worried and exhausted and talks irrationally when he is physically tired. This should be remedied by strict adherence to regular hours of sleeping and by his being very careful not to work too hard or for too long periods of time. He should also have meals of a wholesome, nutritious type at regular intervals. He should have plenty of regular physical exercise and normal recreation. However, he should avoid any excitement or pleasure of an adventurous, hilarious type. A person who has just checked a severe case of tuberculosis must be very careful not to let his body run down from lack of nourishment or from lack of rest and recreation,

and the same is true of a mental trouble such as the one which Mr. Brown suffered, for any strain or weakening of the body increases nervous weakness and makes a person susceptible to a 'nervous breakdown'.

"By the way, have you ever read *A Mind That Found Itself*, by Clifford Beers? If not, you might be interested in reading a copy that we could loan you, for it is the story of a man who suffered from the same type of ailment that Mr. Brown had and it relates how he came out of his illness. I think this book by Mr. Beers really started the modern movement for mental hygiene, which is endeavoring to make conditions better for people suffering from mental and nervous trouble and to increase the public's interest in mental and nervous conditions, so as to keep us all alert to the forces around us that influence our efficiency.

"The mental-hygiene program is somewhat analogous to the anti-tuberculosis crusade of the present, which seeks not only to remedy the conditions of those who are ill, but to build up the health of the whole population, for preventive purposes."

Procedure in this case consisted of: (1) giving social data to the doctor in the district offices of the United States Public Health Service and the Bureau of War Risk Insurance; (2) securing information from the state hospital in which Mr. Brown had formerly been a patient; (3) placing data before the Federal Board for Vocational Education in order to secure advisable placement in training; (4) urging removal of irritation of guardianship after having received authorization from the Bureau of War Risk Insurance; (5) referring the Home Service secretary to literature that would throw light on the problem of this particular patient and explaining to her how to go about creating a more favorable attitude in the patient's home.

Psychiatric case correspondence has not been established long enough to draw definite conclusions from it. However, certain principles have revealed themselves in the experiences accumulated from month to month in developing psychiatric social work by correspondence. They can be summarized as follows: (1) make explanations as clear as possible in order to give the Home Service secretary sufficient background with which to work; (2) never write a letter upon one topic at a time, but always construct a picture of the problem as a whole; (3) employ simple language and a simple style and avoid a technical atmosphere and vocabulary; (4) attack each case with such freshness of point of view that the person whose

services are enlisted in its behalf will realize that the matter is of vital individual importance even if it is only one instance in a vast program of activity; a perfunctory letter will inspire perfunctory responses; (5) formulate each letter, not from the point of view of shifting work out of the office, but of getting replies with results. These principles, which have evolved from the past few months' experiences, corroborate the general rules given in Mary Richmond's *Social Diagnosis*.[1]

In the commercial world, people are beginning to realize the importance of correspondence as a business factor and are paying more and more attention to it. If business men are paying attention to the relations of correspondence to efficiency, social workers should certainly do the same, since there are such various factors that influence the efficiency and success of social case work. Application of expert technique in the field of social case work means not only a saving of dollars and cents, but a saving of human energy and human welfare.

[1] "What method of presentation will most interest him [the local correspondent] and so win the information or the service? How, for instance, can the trouble to which he will be put by the inquiry be justly measured, and every effort be made to anticipate his difficulties and give him the details that will help him to overcome them? If the correspondent is not personally known, as often happens, what circumstances of his occupation, experience, education, and of his relation to this particular problem should be borne in mind and turned to account in the attempt to make the significance and possibility of the inquiry clear to him?" *Social Diagnosis*, p. 320.

"This longer view . . . enables us, in writing to them, to leave a window open, to suggest a prospect beyond the immediate details about which we are concerned. It is this prospect, this relating of small details to helpful and constructive results in the near future, that will most surely interest them in our request and fire them with a desire to have a share in this particular social undertaking. Not many words will be necessary, but something of our real interest, something more than mere processes, must be suggested." Ibid., p. 327.

THE SPECIALIST

MARTHA HASKELL CLARK

ONE at a time the waiting line lagged by,
Each with his tale of shattered nerves and life,
A household servant worn with drudgery,
A schoolgirl overtaxed, an unloved wife;
A sullen, frightened youth with sin defiled,
A fur-wrapped matron fumbling with her glove,
A sleepless mother mourning for her child,
A soul-starved spinster hungering for love.

Pale wraiths of women, gaunt-eyed wrecks of men,
I saw them pause and gather heart again.

To each he gave the best he had to give:
To one, the age-old master-words, "I can!"
To one a fresh incentive still to live,
To one, a new-found faith in God—and man.
But to them all he gave himself unspared,
Not loftily aloof, nor heedlessly,
But to the dregs each bitter cup he shared
And poured them endless wine of sympathy.

They seemed to me, who watched them there apart,
Like unclean leeches fastened on his heart.

But once, between one patient and the next,
His glance sought swift a picture on the wall,
Like one who reads an old and well-loved text—
A range of fir-pricked mountains, that was all.
Yet suddenly I knew what balsamed air
Had cleft the room's wan atmosphere of pain,
To linger one cool, fragrant moment there
And hold him calm, and quiet-eyed, and sane.

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ABSTRACTS

WHAT THE STATE DEMANDS OF ITS SENTINELS OF MENTAL HEALTH. By Donald A. Laird. *Medical Record*, 100:500-4, September 17, 1921.

The author's point of departure in this paper is the self-evident proposition that the mental health of the community must be secured by work done in the community itself rather than in the wards of state hospitals. Mental hygiene is a phase of general hygiene and as such lies properly within the field of preventive medicine. The predominant tendency in all modern health work is to pass beyond the hospital, clinic, and dispensary and enter the everyday lives of the people of the community. Mental hygiene should be no exception. It should focus its attention upon causes rather than upon irrevocable effects. "The mental hygienist should concentrate his prophylactic efforts upon the everyday activities of the personality in the household, in the street, in the factory, or in the forum."

The attempt is sometimes made to distinguish between "normal mental hygiene" and "abnormal mental hygiene". The author questions whether the latter term is permissible. "Strictly, yet broadly, defined at present, hygiene is 'that department of knowledge or practice which relates to the maintenance of health' (*New Oxford Dictionary*), or 'the science that treats of the laws of health and methods of their observance' (Gould's *Practitioners' Medical Dictionary*). And plainly enough, beyond all controversy, the maintenance of health and the observance of the laws of health are far more than merely the absence of disease. Evaluated in terms of the accepted present-day designations of hygiene in fields other than mental, we find that so-called abnormal mental hygiene is an imposter. . . . There is a place for abnormal mental-health work in the field of public health, but this is a *sanitary* science and not hygiene. Those psychiatrists who concentrate their efforts and attention upon institutional cases and overt maladjusts may be furthering knowledge and rehabilitating their patients, but they are not, *ipso facto*, hygienists. Not until psychology, psychopathology, medical psychology, and medicine use their hygienic tourniquets to dam the flow of personality into the state hospitals and sanitaria will the term mental hygiene be more than flimflam and mockery."

The author does not mean by this to discredit the splendid work that has been done in mental hygiene by the central agencies organized for that purpose. They were the pioneers who blazed the trail. But the time has now come when the greater part of the active

work in this field should devolve upon the local custodians of the community's mental health.

"It is these local mental hygienists, who have their fingers continuously on the pulse of the community and the personalities of that community ever under observation, who will render greatest aid in lessening the flow of these personalities toward the colossal monuments to mental as well as physical and social maladjustment—the state hospitals. As in the case of typhoid fever, for example, where sources of infection must be guarded against and carriers identified and freed from their potential danger to the body politic, and where it is essential that the patient be given early treatment and not simply care, so in mental adjustments the possibilities for undesirable and pernicious adaptations must be guarded against individually and collectively and the early prodromal signs of maladjustments observed, that readaptations and regulations may be effected. Those to whom this duty falls are the outposts, the sentinels of mental health. Theirs is the most imperative and constructive work in the conservation of mental health, happiness, and social and economic values."

These sentinels include clergymen, teachers, lawyers, parents, social workers, and many others, but one stands out above all the rest—the family physician or general practitioner. So far as constructive work in mental hygiene is concerned, the general practitioner is in a far better strategic position than the specialist in mental disease, who deals for the most part with cases in which the general practitioner has either neglected his functions as a custodian of mental health or has failed to perform them adequately.

In view of this supremely important position of the general practitioner in relation to the community's mental health, it is pertinent to inquire what use the state is making of his services in this field. Even in progressive states to-day practically the only demand that is made upon those services is in passing upon cases for commitment. "The state is apparently unconcerned with the personality of its citizens before deterioration is so far advanced or so badly disordered in its functioning that the commitment stage is reached."

Moreover, the qualifications required by the state for even this narrow responsibility in mental-health work are inadequate. The state medical licensing and examining boards, which pass upon the fitness of those who would practice medicine in the respective states, determine that fitness according to certain prescribed standards—usually graduation from a "recognized" medical college, a certain moral character, a few educational requirements, and an examination by the board. "The most that the state boards can expect from their candidates at present, aside from a special interneship or other special

training after graduation, is a diploma from a class A medical college. And what specific preparation for work in mental hygiene, either in a broad or a narrow sense, can be universally relied upon from graduates of these class A medical schools?

"In defining the standards to be met by acceptable medical colleges the Council on Education of the American Medical Association wisely permits of a short range of eclecticism in the clinical years of instruction. Certain clinical requirements are definitely stipulated, however. Such is the case in obstetrical experience. But nothing is set up as a goal for nervous and mental diseases or psychiatry or mental-health training. It is stipulated that hospital facilities shall be available for children's diseases, contagious diseases, and nervous and mental diseases. No definite experience is particularized, however, and definite instruction in psychiatry is not mentioned. None of the premedical educational requirements specified for these acceptable schools includes psychology as a *sine qua non* for preparation, so one cannot expect the final product of the class A school to be invariably or usually equipped with the background essential for a comprehension of the 'normal' mental hygiene which we have found is the real hygiene.

"Only a limited number of the acceptable schools have a separate department of psychiatry or a distinct professor of psychiatry. What instruction is given in this field is usually by 'bicycling' or by calling upon a state-hospital physician for a few lectures. Instruction is usually of the manikin type and the clinical experience is incidental and vicarious. Many schools are frankly reluctant to include psychiatry in their curriculum which is 'already crowded with more necessary subjects.' . . .

"And just what do the state boards exact from their examinees as a demonstration of capability in mental hygiene? We will find an answer to this in the complete questions which are at hand for one state-board examination in each of twelve states in 1920. A total of 1,051 questions are in these examinations. There are seven questions out of this number which can definitely be considered as directly testing the candidate's fitness as a sentinel of mental health. These seven crucial questions were distributed among four states only. The remaining eight states made no effort during the year in question to probe their candidates' fitness in this respect.

"Of the four states that did consider their practitioners' capability as mental hygienists of sufficient importance to examine into this phase of their information, we find one state asking four questions (out of 120) on this topic. This state was Texas. Three of these questions were included under jurisprudence and one under pathology.

Two other states included one pertinent question under the quiz on practice of medicine, while another state had one under obstetrics. . . .

"Obviously the general practitioner is rarely qualified for even giving the advice in commitment cases requested from him by the state. And as sentinels of mental health, one can rationally expect but little from this group."

As an example of what is being done to better conditions, the author cites the case of the Board of Registration in Medicine of the Commonwealth of Massachusetts, which "is considering demanding a medical course in psychiatry or nervous and mental diseases from its candidates.[1] It is also probable that at a future date this progressive board will notify the medical schools that all applicants will be examined in neurology, including psychiatry. . . .

"There are a few states which have the facilities available for training in mental hygiene as a state project. The licentiates could be given training at these centers before being permitted to practice and with bounteous remuneration to the state as well as to the embryo practitioners. To take New York State as an example, this state has a splendid psychiatric institute on Ward's Island which is used largely for the training of physicians in the service of the state hospitals. If it has been found necessary to provide special postgraduate training for those in charge of the overt and total maladjusts, there is certainly greater need for training those whose duty it is to nip in the bud, so to speak, the potential and the beginning maladjusts. And in the case of New York State one finds an established institution which is admirably fitted for giving that training."

From the economic as well as the hygienic standpoint, present conditions are a menace. The passing of 60,000 persons annually into the state hospitals for mental diseases is a waste that must not be allowed to go unchecked. "As a sentinel of mental health, the family physician is the keystone in the arch of hygienic progress, and not until the states demand adequate qualifications for this sentry duty will the ebb and flow of human personality between disease and inefficiency be lessened."

Neuroses in Business Life. By Louis Casamajor, M.D. *Neurological Bulletin*, 3:237-42, July, 1921.

The problem of the industrial neuroses, which has assumed such importance since the advent of workmen's compensation laws and compulsory accident insurance, is complicated by the fact that these

[1] A law enacted by the 1921 legislature, to become effective July 1, 1923, includes psychiatry as one of the subjects in which applicants for registration as physicians in Massachusetts must be examined.

neuroses so often develop where there is no possibility of a claim for compensation.

"To study only those industrial neuroses in whose causation an element of trauma may be included and where compensation is a possibility, is to observe only one phase of the question. Were desire for compensation the only factor, the problem would be simple. It would then be a question, not of neurosis, but of malingering; in other words, the desire to be sick would then be conscious rather than unconscious, as it is in the neuroses. Certainly this is untrue in the vast majority of cases. Osnato stresses this point as follows: 'The Compensation Law of this state (New York) allows a maximum weekly indemnity of $15. Certainly this sum can be earned by the average laborer even though he is not particularly skilled. Besides this, many patients are married and have families and there is every reason for them to return to work as soon as possible.' Again, were these neuroses unknown in business life, where there can be no claim for compensation, there would be less difficulty in their interpretation. This also is far from the truth. Such neuroses are very common, but usually pass unnoticed, for the monetary asset value of the neurosis is absent, the patient has no claim on his employer, and the relationship of the work to the neurosis is overlooked."

The present paper is a discussion, illustrated by case histories, of a number of cases of such neuroses examined by Dr. Casamajor during the past two years. The neurosis in each case was quite unassociated in the patient's mind with his employment, but the underlying mechanism was the same as in the compensation neuroses, and Dr. Casamajor feels that if any of these patients had sustained a trauma in connection with his work, he would have developed the typical traumatic neurosis.

The patients are divided into three groups: the adequate, the dissatisfied, and the generally maladjusted. No case belongs exclusively to any one of these three classes, since elements of all three are to be found in each. One outstanding feature is common to all: no one was satisfied with his job. All of these patients had many good reasons for being satisfied with their work, but they had also reasons for being dissatisfied—usually reasons that they were ashamed of and did not want to admit even to themselves. "These latter reasons were more or less unconscious, and it is in this conflict of reasons that we see the causation of this neurosis as of every neurosis, both in civil life and in war."

The three groups are described by Dr. Casamajor as follows:

"The inadequate is the individual who is not equal to his job. When he finds himself in a position which is beyond his ability, he becomes fearful that he will not succeed. He dislikes responsibility

and would prefer to earn his living in an easier way. To do so, however, would reduce his income, and he finds himself with a real conflict on his hands. Primarily, he is afraid of failure, and his illness (neurosis) is an excuse for failure and a reason for not attempting success. The onset may be at any time and is usually induced by a change in the patient's working conditions, either promotion to a position of greater responsibility and beyond his capacities, or a misfortune which complicates the business life by requiring greater responsibility and activity. Since fear lies at the basis of the mechanism, anxiety is the principal symptom of the clinical picture."

The dissatisfied group is the largest of all, including as it does the great majority of the neuroses of business life. "We nearly all belong at least in the border-land of this group, but most of us do not develop neuroses to solve our difficulties. The neurosis arises in the individual who likes the remuneration he gets from his work, but dislikes the work itself and the type of life it forces him to lead. The symptoms are not usually severe and most of these patients struggle on without applying for medical aid. However, should the patient suffer an accident for which the employer could be held responsible, a typical traumatic, litigation neurosis might easily appear. Many of these patients are young men who have served in the army and have had considerable difficulty in readjusting themselves to civil life. Life in the army, while not an ideal one, nevertheless is not totally unpleasant. It has its advantages in the strong patriotic emotion, a certain prestige, and a freedom from great financial worry, which appeal even to the moderately indolent. . . . As a rule these patients recover rapidly under analytic and suggestion treatment."

The third group are those whose difficulties in business life are only a phase of their general maladjustment. Their difficulties with their home life are of much greater importance, and their work is often a means of escape from the home. These cases are deserving of consideration, however, because they are the ones that after a slight trauma most easily develop into typical litigation neuroses.

Considering the artificial conditions of life in our great cities, Dr. Casamajor wonders that the neuroses of business life are not more common.

"When an injury for which an employer can be held responsible occurs, such dissatisfaction can be capitalized unconsciously and the traumatic neurosis becomes the logical sequence. Bailey has emphasized the other side of this same picture in describing his experiences in the wreck of a 'Banker's Special'. Of the 150 men on this train, all men of position and fairly well satisfied with their lives, 'not a single one developed a traumatic neurosis and no claims of any importance were brought against the railroad company'."

KLINISCHE UND GENEALOGISCHE UNTERSUCHUNGEN ÜBER "MORAL INSANITY". By Frederick Meggendorfer. *Zeitserift für die gesamte Neurologie und Psychiatrie*, 66:208-231.

Meggendorfer has collected 100 cases of psychopathic delinquents whose histories are obtainable over a period of from ten to forty years, and has attempted to study them in the light of those histories. Many of the cases had come into the institutions when they were young, and a number of years had elapsed, so that he was able to get a perspective on their lives. In this paper he has divided these patients into several groups. He considers only two groups, one that he characterizes after the manner of Kraepelin as *affect epilepsy* and another that he terms *parathymia*.

He would have it understood that he does not relate the affect epilepsy to true epilepsy. In a few cases of true epileptic attacks, occurring before the classification of affect epilepsy has been made, the psychic structure rests upon the basis of seizures. As a rule, these patients as children are very difficult. They are restless, have many and long tantrums; later they are very irritable, vain, tease their fellows, and plague their teachers. Often they are intelligent and virile young people. But early they show a tendency to lie, deceive, and swindle. In many of them appear conditions that suggest the mood change of epileptic attacks. The attacks simulate true epilepsy, and often cases show what might be considered a status. One can also observe other epileptic appearances, such as *petit mal*, dizziness, confusion, and fugues. However, the typical character changes of genuine epilepsy and of epileptic dementia are absent; therefore, the attacks are frequently related to hysterical attacks. Besides the affect epilepsy, these patients have conditions that Meggendorfer characterizes as affect drunks, affect deliria, and affect *dämmerzustande*. After these attacks have passed, it is thought that the patients have simulated. In institutions these patients tend to show hysterical signs and theatrical manners while the attacks disappear, but as soon as they leave the institution, they begin again.

Meggendorfer gives six family trees of patients of this group, showing a very great amount of psychopathy without marked evidence of psychosis, feeblemindedness, or epilepsy. He considers that this familial tendency is the corner stone of a certain psychopathic constitution and that in the course of generations there results a picture with a new combination due to the polymorphous heredity. The prognosis in this group—and this includes some very severe cases—is in general quite good. Around the twentieth year there is a tendency towards stabilization. The great danger to this type is alcoholism. In the statement of prognosis he gives the following: one case, twenty-nine years of age, for seven years has done well; another,

thirty-one years of age, social behavior good for ten years; another, thirty-two years of age, satisfactory reactions for twelve years. A thirty-eight-year-old individual showed no gross disorder for thirteen years. Still another, forty-four years old, has been reacting in a social manner for eleven years.

The second group, characterized by the term parathymia, as children show a tendency to great pride and opposition to control. Later a tendency to lying appears, or on the other hand they may be easily influenced and hang heavily on their parents. In school they do quite well, but their general tendency is to become from year to year less satisfactory. In their higher classes they are flighty and given to fancy. They become restless and difficult. They hold back from their fellow students. Frequently they appear pale; they acquire a habit of masturbation. They mature young. Girls of this group are easily led and seek sex gratification, and as a rule become prostituted. In school they have no interest or further tendency to study, though the teacher has the impression that they could do well if they only would. They become difficult, tactless, and impudent toward their relatives. They draw away and lose all their former tenderness. Toward strangers they are quite different, however, and tend to flatter and try to make a good impression. They tend to spend a lot of care upon their persons, dressing in the latest mode. Signs of affection toward the family vanish; they are without tact and without shame. The young men get into great financial difficulties and stop at no means to gratify their own ends. When they arrive at an institution, they show no definite psychotic manifestations. However, upon a very careful examination, there is evidence of vague, flighty, visional and auditory misinterpretations; also ideas of being influenced and persecuted. Their ability to follow a line of thought does not seem to be disturbed. However, they are often very superficial. There is no critique of their own motives. They lie often in the face of facts and try to put the blame on others. Sometimes they are repentant, but more often they have no shame or understanding of their acts. They are not interested in the situation. Their attitude toward their relatives is brutal; they are quite self-confident—see no difficulty in the future. When relatives or parents come to visit them, they become excited and angry. Occasionally they are somewhat depressed and anxious, and have hypochondriacal tendencies. When long observed, they show a certain lack of any goal in their thoughts and acts. They frequently seem to deteriorate and seek their outlets in various crimes. So they vary between freedom, imprisonment, and institutions for mental disease. Only in rare instances do they stabilize in later life.

Meggendorfer gives five family trees of such patients. In this

group one sees a considerable amount of mental disease, particularly dementia praecox, either in the ascendents or in the collaterals. He feels that the patients themselves show signs that are closely related to what one sees in dementia praecox, and he believes that they belong to the type of psychopath who has a certain relation to the schizophrenic. He doubts whether it is fair to call these people psychopathic, meaning by the term the constitutional anomaly in which the condition in these diseases lies between normal and abnormal. He says it is very doubtful whether these patients show this condition. Thus, for instance, the first patient of his group in his youth was an industrious student, showed great love for his mother, sisters, and brothers, and only later lost this interest and fell away from his parents and brothers and sisters. In place of the affection of the earlier life there developed a tendency to hate and to draw away; he separated more and more from the conditions of his family and became criminal. Somewhat similar conditions were seen in the others. Meggendorfer believes that these cases are related to schizophrenia.

As to the basic symptoms of schizophrenia as conceived by Bleuler, there is much in common between patients of this type and the schizophrenic. Meggendorfer considers that there is an ambivalence in Bleuler's sense. The patients lose interest in their former tendencies and desires, in family and social relations. There is a lessening of feeling. Parathymia is indeed the chief sign of these cases. Phenomena of ambivalence and ambitendence are observed. The patients love and hate the same object at the same time, and in their relations to their surroundings, their thoughts, and feelings, and their acts, they show antithetic tendencies. In the sense of Bleuler, they present accessory symptoms of schizophrenia as flaccid appearance. The sign that Kraepelin considers the fundamental of dementia praecox—"a weakening of the emotional control which directs the impulsive tendency of our wills"—is present. If one sees in these above mentioned factors the intra-psychic ataxia of Stransky, the similarity is more marked. The disorder usually appears about the time of puberty. It develops either in an abnormal, fine, quiet, model child or in a nervous, irritable, headstrong child such as we see in a case of undoubted schizophrenia. In general the prognosis is unfavorable, but occasionally we see an improvement with residual defect. The continual change of mood, the social inabilities, are indeed a sign of mental deterioration, as is the intellectual deterioration. Meggendorfer would feel that this is most closely related to the hebephrenic or probably what Kahlbaum has described as heboidophrenia. The real difficulty is a deterioration of mood—therefore, the name parathymia.

BOOK REVIEWS

A Mind That Found Itself; An Autobiography. By Clifford Whittingham Beers. Fifth edition (revised). New York: Longmans, Green, and Company, 1921. 368 p.

It is not given to every man to turn his misfortunes to good account, nor is it always feasible to contribute through one's own ills to the welfare of society. Mr. Beers, the author of this book, has been able to do both.

Now a successful man in early middle life, both mentally and physically vigorous, the author can look back to a period, from his twenty-fourth to his twenty-sixth year, when he was far from being either healthy or happy. Indeed, during these two years he was insane. But fortunately he suffered from a type of psychosis that passes. He made a good recovery.

Most persons who recover from mental disturbance put the experience as far as possible out of their minds. They try entirely to forget it. They never willingly refer to it. Their friends and relatives enter into a conspiracy of silence regarding it. Though Mr. Beers has, we may assume, felt a similar inclination, at times at least, luckily for the world he has overcome it. He has given us in this volume a personal account of mental suffering that is unique in the annals of psychiatry.

Not that the author of this book is the only person who has been insane and recovered who has written an account of his memories of the disturbed period; there are a number of documents of this sort extant. But Mr. Beers' account is unique because of its literary quality—it is distinctly a contribution to general literature—and also because it has become the starting point of an important social reform. Most autobiographies emanating from minds that have been disordered, even from those that have returned to a healthy state, have not been remarkable either as literary contributions or as stimuli to social betterment.

Many men capable of judging have commented upon the literary merits of Mr. Beers' autobiography. Professor Lounsbury has said that though truthful documents are unapt to be well told, Mr. Beers' account is both truthful and well told.

The late Professor William James read the manuscript before it was published and wrote that the author had "handled a difficult theme with great skill and produced a narrative of absorbing interest to scientist as well as layman". And the late Cardinal Gibbons, who

read the first edition, said of it: "To me it is a wonderful book. I scarcely remember having read anything which stirred me so deeply or left upon my memory stronger or more vivid impressions." For its literary value alone Mr. Beers' autobiography may in the future be grouped with De Quincey's *Confessions of an Opium Eater.*

From the standpoint of social reform, this book marks the beginning of an epoch. When he wrote the book, the author had in mind predominantly the remedying of certain abuses connected with the treatment of insanity, and starting work in the prevention of mental diseases. The publication of the volume has contributed to these ends. It has, however, done much more. It started the broad health movement that is now represented by the work of The National Committee for Mental Hygiene, a social contribution everywhere recognized as of high value.

In the revised, fifth edition now before us, the contents have been rearranged to the advantage of the reader. The story of the author's experiences now appears as a continuous narrative, separated entirely from other matters. The mental-hygiene movement and the work of The National Committee for Mental Hygiene are dealt with in an appendix.

Readers not already acquainted with this narrative of Mr. Beers have a thrilling experience before them, for its interest exceeds that of most novels, and yet the story is not fiction, but the author's actual remembrances of his experiences. Mr. Beers, on recovery from his illness, became a zealous reformer, in the best sense of that much abused word. He organized The National Committee for Mental Hygiene in 1909 and has from the beginning served continuously as its secretary. The account he gives in the supplementary material at the end of his book of the National Committee, of its organization, of the scope of its work, of the plan for an "International Committee", and of some of the plans for the future, makes very interesting reading by itself, and is soon to be issued as a sequel to his life story. But the book is to be recommended not alone for the influence it may exert in favor of the mental-hygiene movement, but also and especially on account of its intrinsic literary merits as an autobiography.

Lewellys F. Barker.

Baltimore, Maryland.

Human Behavior in Relation to the Study of Educational, Social, and Ethical Problems. By Stewart Paton, M.D. New York: Charles Scribner's Sons, 1921. 465 p.

There has been a steadily growing tendency in psychiatry to broaden our view, as well as the field, of the neuroses and

psychoses. In no department have there been such pronounced advances as in that of gaining a better understanding of the basic concept of personality and character. As a contribution to this end, Paton's book is invaluable. In such chapters as the following he outlines the increasing need of the study of human behavior: *The Study of the Individual in Relation to Educational and Social Problems; Special Mechanisms of Adjustment; The Development of the Personality; Organization and Synthesis (Temperament, Character, and Intelligence); Controlling Mechanisms (Inhibition); Factors Determining the Trends of Activities (Dispositions); Habit Formation; Involution of the Personality; Imperfect Organization of Activities (Conflict and Dissociation of the Personality); The Intelligent Direction of Activities (Education); The Study of Man in Relation to the Progress of Civilization.*

The author indicates the complexity of his subject and the different methods by which it may be undertaken, and points out the manifold difficulties that beset such investigations. Contrary to what has recently been urged in some quarters, there is really a "psychiatric point of view", at least one that is still in sharp contrast to the usual mechanistic attitude of attack by many neurologists in the study of a neurosis. In short, the psychiatric viewpoint is the biologic one and has been markedly so since dynamic psychology has been to the fore. What is this biologic approach? It literally concerns the living activities, the human behavior of a functioning being as a whole. It embraces its heredity past, its present, and its portent of future adaptations to living conditions. Unfortunately Paton more than once contrasts heredity and environment in contradistinction to the personality *per se*. These states are so interrelated that they are quite indissoluble. Perhaps Dr. Paton has found it difficult to use exclusively such terms and phraseology as the intelligent layman may understand, but he has succeeded beyond most expectations. The work is entirely readable and one worthy of full recommendation.

L. Pierce Clark.

New York City.

The Psychology of Subnormal Children. By Leta S. Hollingworth, Ph.D. New York: The Macmillan Company, 1920. 288 p.

This book is well written, brief, and clear. In make-up it is attractive, the print being large and the paragraphing such as to attract the eye.

Dr. Hollingworth has used as her material for the book not only her own acute and constructive observations and studies, but she has also incorporated the experiments and findings of many physicians,

psychologists, teachers, and all those engaged in any study in the field of mental deficiency. The findings have been carefully analyzed and are clearly presented. The result is a book that is a digest of all the findings concerning the various phases of mental deficiency.

The comprehensive scope of the book may be seen from an enumeration of the sixteen chapter heads: *Individual Differences; The Scientific Study of the Mental Defective; The Definition of Mental Deficiency; Identification; Are the Defectives a Separate Species? Arrested Development; Are the Feebleminded Equally Feeble in All Respects? Physical Traits of the Feebleminded; The Instincts and Emotions of the Feebleminded; How Do the Feebleminded Learn? Can the Feebleminded be Made Normal by Any System of Education? The Causes and Prevention of Mental Deficiency; Secondary Causes; Nervous and Mental Disorders Which May Complicate Mental Deficiency; Special Classes and Special Schools.*

Of especial interest at this time is Dr. Hollingworth's discussion of the relation of physical defects to mental deficiency. Nutrition classes, remedial operations for adenoids and tonsils, treatment for carious teeth, and broadening of the dental arch are still advocated by many not only for the benefit of such procedure to the general health, but also as a cure for mental deficiency. Dr. Hollingworth points out that primary mental deficiency is due to a defective germ plasm, and that there is no scientific evidence that the removal of the tonsils or the treatment of carious teeth "have the slightest effect on the intelligence quotient". In this, of course, Dr. Hollingworth represents a point of view that is in keeping with her own training and experience, but not one that is held by many other investigators whose training and experience have been different. Many physicians believe from their clinical experience that treatment of physical handicaps and proper feeding do improve the intelligence of children. Whether this is so or not so cannot be stated with finality, of course, until these cases are checked up both before and after treatment by psychological tests.

In discussing the effects of physical handicaps on the mental development, Dr. Hollingworth brings out the much neglected point that the physical difficulties often assigned as causative in the case of the person of low intelligence are found also in children of superior intelligence. A study was made of a group of twenty-five superior children, only six of whom proved perfect physically, the rest having such physical defects as carious teeth, enlarged tonsils, defective nasal breathing, orthopedic defects, malnutrition, and overweight. The intelligent quotient of this group (median I.Q.) is 137. The fresh and interesting viewpoint of the author is brought out by her further comment: "One would be laughed out of court who would undertake

to prove the very superior intelligence of these children to be due to their carious teeth, enlarged tonsils, malnutrition, and so forth. And yet the same array of data in the case of the subnormal has sometimes led to an inference as inadmissible. The fact is that we find physical defects scattered throughout the whole range of intelligence, and the relation between the two is almost wholly unknown, except in the case of neurological disorders."

In the discussion of the small group of secondary causes, she indicates briefly the outstanding points in the relation of syphilis, the ductless glands, abnormal growths in the brain, hydrocephalus, encephalitis and meningitis, epilepsy, injury to the cranium, and accident and disease not hereditary.

The amount of space devoted to these subjects is not in accordance with their very great importance.

In discussing whether or not the mental defectives are a "special species", the author takes the stand that they differ from other members of society not in kind, but in degree.

The author brings out some very vital facts concerning the education of the f ebleminded, their learning rate, the transfer of training, the sensory ability, and the value of sensory training. The book contains many charts of an interesting sort, covering such fields as the variability of the feebleminded and their relation to the normal.

The author states in the preface that the book is addressed primarily to teachers engaged in this field and to clinicians, and that relatively little emphasis has been placed on diagnosis and on identification. Nevertheless it should prove helpful not only to the special teacher, but also to the general teacher of the grades, to the social worker, and to the physician. It should be of special value to the school physician.

This book should find a place on every library list of public schools, parents-teachers associations, social workers, and speech teachers. It will be of hardly less value to the physician interested, not only in the organic anomalies with which his patient may be afflicted, but also in the problem of adapting the patient to his environment in an intelligent way.

Smiley Blanton.

University of Wisconsin.

The Manner of Man That Kills. By L. Vernon Briggs, M.D. Boston: Richard G. Badger Company, 1921. 444 p.

Dr. Briggs' valuable contribution to our knowledge of the psychology of the delinquent is interesting from various standpoints. In the first place, from the standpoint of the present, it is delightful to read, in Dr. Briggs' concise English, the clinical histories of three psychopaths—Czolgosz, Richeson, and Spencer, whose personalities once

loomed so large on the horizon of public interest. All three were murderers who suffered death in the electric chair in the state of Massachusetts. Spencer terrorized the town of Springfield for several years before 1910 by his childishly daring robberies, which ended finally in the murder of a harmless woman whose house he had entered and whose screams so confused and terrified the psychopathic burglar that he shot and killed her. Czolgosz, who killed President McKinley and whose crime is too well known to need description, was mentally deficient; while Richeson, the handsome Baptist clergyman of Cambridge who poisoned the girl to whom he was engaged when he desired to marry another woman, was also a mentally abnormal type.

From the standpoint of the future and especially from that of the valuable legislation that Dr. Briggs proposes and a part of which has already been enacted by the Massachusetts legislature, the book gives to those of us who are struggling day by day with the problem of the defective delinquent a distinct message of comfort and of hope.

Finally, from the standpoint of the past, the reader who can put himself back ten years into the mental atmosphere of the public mind at that period must be impressed most of all by the calm determination with which Dr. Briggs upheld his scientific ideals in the face of almost universal condemnation and even of personal abuse. When Dr. Briggs publicly opposed the execution of Spencer and later of Richeson, on the ground that these men were not entirely responsible for their actions although they could not be classed legally as insane, he exposed himself to a storm of misunderstanding that he bore with a dignity and a self-restraint that is seldom met with in prophets and reformers who are mentally ahead of the time in which they live. It must be for Dr. Briggs a source of deep satisfaction to realize that the ideals for which he once fought so bravely have been generally accepted by scientific men and are gradually being disseminated in the minds of the average man and woman of our day. The many newspaper clippings that Dr. Briggs includes in his book give the reader some idea of the great advance that has been made in public judgments of defective delinquents during the past ten or fifteen years. Dr. Briggs places the blame for such crimes as the murders committed by Czolgosz, Richeson, and Spencer firmly on the society that allowed these abnormal personalities to develop along psychopathic lines without interference and without any effort to alter or restrain their development until it ended in murders that shocked the sensibilities of the entire community. He urges that when such crimes do happen, the criminal, if he be mentally deficient or psychopathic, should not be executed, but should be sentenced to

life imprisonment, during which his personality can be studied and such lessons learned from it as will help society to recognize similar types in the future and to deal with them before they become dangerous to the community. For these reasons Dr. Briggs' book should have many readers, for it is fascinating to the layman and extremely valuable to the man of science. Moreover, the legislation that he suggests should receive the attention of our more enlightened legislators. Dr. Briggs himself may rest assured that his colleagues deeply appreciate all that he has done.

John R. Oliver.

Medical Service, Supreme Bench of Baltimore.

The Manhood of Humanity: The Science and Art of Human Engineering. By Alfred Korzybski. New York: E. P. Dutton and Company, 1921. 208 p. (Appendices, III.)

This book has been so much praised—it has been called "epoch making"—that, having finished it and found little of value in it, one wonders if possibly the point of it all has been missed. But on looking through it a second time, it does not seem that the main points have been lost. There are, apparently, three of these, and as they are mentioned in each chapter, not once, but several times, to the verge of tedium—in fact, the author never seems to get at the real problems of the "science and art of human engineering" because he is so occupied in belaboring his three points—it is impossible to miss them. These points are: (1) Man is not just an animal; (2) Neither is he a combination or union of animal with something supernatural; (3) Man is literally a part of nature and of a different "dimension" than animals. By this latter, the author means that man is distinguished by "time-binding qualities"—human beings are "time-binders". (Plants are "chemistry-binders" and animals "space-binders", according to the author.)

The expression "time-binder" is the best contribution the author makes. While there would seem to be nothing new in the conception of "time-binding", the expression itself is a happy one, so rich in imagination that one is surprised to find it in a book on "engineering", praised by engineers and mathematicians, until one remembers that genuine imagination lies rather with the engineer and the mathematician than with the poet and philosopher, as is so commonly supposed.

Count Korzybski is very much in earnest about these three points, and while it does not seem possible that an intelligent person would take serious issue with any one of them, he would seem to feel that the intellectual world is armed to the teeth against them. We have,

therefore, not so much a book on the "science and art of human engineering" as a book devoted to proving that man is not just an animal, is not part animal and part supernatural (in fact, is not supernatural at all), and is more than animal because he has a fairly long memory (time-binding quality) and can use it; with a promise that more may be said later, but that not until we have grasped these points will we sufficiently understand human nature to consider undertaking human engineering. One gets the impression, somehow, that the author has been a very busy man in fields quite apart from human engineering—he is a military man, one gathers—but that, as an avocation perhaps, he has let his mind ruminate on some of these problems until he has come to the same conclusion as a good many others—that the greatest study of man is man; only, Korzybski stops here while others have pushed on from this point and have tried to understand man. It is quite evident that while Count Korzybski has been thinking on these problems, he has not been studying them in the sense of ascertaining what data already exist on the subject of human engineering. It is a bit as if an engineer came forward, year 1922, with a book announcing that there is no reason why a heavier-than-air machine should not fly; that it is important that we develop flying machines, as they would have a use both commercial and military; and that he believes he is on the track of principles that will make flying possible—evidently not aware that the Wright brothers flew eighteen years ago and that there has been considerable successful experimentation and development of aëroplanes since.

The general practitioner of medicine, and the layman, frequently complain that the psychiatrist uses a language—a "jargon", they call it when something eludes them—that they cannot understand. They seem to feel that something is being kept from them, that somehow it should all be made a little easier for them. They are not altogether wrong in this, although they forget that every profession, even every occupation or trade, has its own specialized vocabulary: that the reasons for this vocabulary are definite and important and even apparent, if one stops to think, and that one cannot expect to understand technical matters of law, or architecture, or bookkeeping, or farming, or the teaching of English, without first becoming acquainted with some of the special terms commonly used. One can imagine an engineer, for example, frowning at the technical terms in Paton's *Human Behavior*—why does the man hide behind these words? It is interesting to see, therefore, how simply things can be stated for the engineer. Here, for example, is Germany mobilized:

". . . a state is the governing center of an accumulation of human beings—of time-binding powers—increasing exponential functions of

time. These powers, though the same in kind, differ in degree and in respect of individuality. If they are to be united so as to constitute a whole, they must be given a common aim; they must, so to speak, be reduced to a common base; if they be respectively X^m, Y^n, Z^p, and so on, we cannot unite them and compute the whole by adding the exponents; but if we give them a common base—a common aim or purpose—then we can readily represent the magnitudes of the whole constituted by them; if we take X to be their common aim or base, then, if $Y=aX$, $Z=bX$, and so on, we shall have:

$$X^m.Y^n.Z^p \ldots = X^m.a^n.X^n.b^p.X^p \ldots$$
$$= (a^n.b^p \ldots)X^{m+n+p} \ldots$$

The last expression, where the parenthetical coefficient is the product of individualities, serves to represent the united powers of all in terms of X, the common base, purpose or aim."

In addition to the contribution of the term "time-binder", Count Korzybski's book will probably be useful in another way. If the book arouses interest in the science and art of human engineering on the part of the President of the International Rotary Club, the Vice-president of the Association of Mechanical Engineers, eminent consulting engineers, and the professors of mathematics at Columbia and elsewhere (all quoted as praising it), it will be the most useful book on the subject yet printed. And if, their interest stimulated, these business men, engineers, and mathematicians wish to continue their studies, they might begin with—a number of books come to mind, but, for example, White's *Foundations of Psychiatry*.

Frankwood E. Williams.

The National Committee for Mental Hygiene.

Psychology; A Study of Mental Life. By Robert S. Woodworth, Ph.D. New York: Henry Holt and Company, 1921. 570 p.

The preface of this book tells what the author intended—that it should be a textbook for the elementary rather than for the advanced student—and this is what it actually is. It is a stepping-stone to advanced work, and yet it is far from being a primer for the unthinking person. To Titchener, the "subject matter of psychology is mind, the direct object of psychological study is always a consciousness"; to Watson, on the other hand, "psychology is that division of natural science which takes human activity and conduct as its subject matter"; and standing between these points of view, Woodworth takes the following attitude: "Psychology is the science of the conscious and near-conscious activities of living individuals. . . . Psychology is

a part of the scientific study of life, being the science of mental life. Life consisting in process or action, psychology is the scientific study of mental processes or activities. A mental activity is typically, though not universally, conscious; and we can roughly designate as mental those activities of a living creature that are either conscious themselves or closely akin to those that are conscious." Among the activities closely akin to those that are conscious are muscular responses that have become habitual, glandular responses such as those that appear in conditioned reflexes, and elements of one's own personality of which one is not aware. Woodworth would include the methods of both the introspectionists and the behaviorists as valid means of psychological study. He accredits Freud with important contributions to the study of personality, though he thinks Freud's theories are open to much criticism.

The subject material is extensive, and this is not surprising, for Professor Woodworth considers that psychology overlaps physiology and biology and is related to all of the social sciences, even economics and politics. He includes many pages of anatomical, physiological, and experimental psychological facts. One of the outstanding contributions that he makes is the application of the idea that tendencies exist in individuals to the determination both of the nature and of the intensity of emotions. He also modifies the James-Lange theory, but mental hygienists are not so much concerned with these technicalities.

Mental hygienists would enjoy and find of value the chapter on will, particularly the section entitled *Securing Action*. They would wish, however, that Professor Woodworth had made more direct applications of his data upon mental life to its problems. The opening sentence of the book would lead one to hope that he meant to make this application: "Modern psychology is an attempt to bring the methods of scientific investigation, which have proved immensely fruitful in other fields, to bear on mental life and its problems." His idea is to present theories based upon laboratory experiment, and not the practical solution of problems, and he evidently expects people to make their own application of his data to the problems of life.

The old question as to whether practical people can be scientific and scientific people practical is always debatable. This book is undoubtedly scientific. Mental hygienists are not yet "scientific", but they are being as practical as possible in their dealings with human problems. They will find in this book a safe and conservative basis for their studies elsewhere, supplying more complete scientific data concerning the functions of the mind than any other textbook on

psychology. It is a dynamic textbook containing material that should be acquired before entrance into any school of medicine or social work.

THADDEUS H. AMES.

New York City.

PSYCHOANALYSIS AND THE UNCONSCIOUS. By D. H. Lawrence. New York: Thomas Seltzer, 1921. 120 p.

One of the curses of this generation is that literacy has far outstript the development of education. In consequence many untrained minds are provided with the jargon of sciences and philosophies which they are incapable of understanding. A further difficulty is that achievement in one field of activity seems to establish the successful man as an authority on any matter on which he chooses to utter an opinion. Because a man can turn out thousands of automobiles at a low price, he finds an audience credulously attentive when he declaims the purest nonsense about sociological or economic theory. No branch of knowledge has suffered more from these tendencies than has psychoanalysis. People who are stupid, people who have no educational preparation for the study, and people who are both stupid and untrained read psychoanalytic literature avidly, and then proceed to ventilate their views and prejudices in psychoanalytic terms. In the book before us we have an example of these dangers.

The author has some reputation as a poet and novelist. His ignorance of biology and psychology is so much more extensive than that of the average cultured man of the twentieth century that one suspects it to have been sedulously acquired rather than a native endowment. With this preparation he has read some psychoanalytic works and now gives us his mystical interpretation of the universe clothed in the language of psychoanalysis. Properly, the subject matter of this book is well adapted to psychiatric analysis—more rational theories are expounded by many a dementia-praecox patient—but since uncritical persons will certainly read the book, it may be well to have patience and examine it as if it were a serious scientific contribution.

Lawrence begins with a statement of the fundamental problem that he finds in psychoanalysis. He refers to the unspeakable horrors of "the *repressions* which Freud brought home to us". At the bottom of every neurosis are incest cravings which do not result from the inhibition of normal sex demands. These incest tendencies also fail to give way before criticism; therefore, they must be regarded as part of normal sex manifestations. What he regards as a logical conclusion is that the repression of incest should be removed. The

inhibitions must be wrong because they produce neuroses and insanity. He says that this is a conclusion which psychoanalysts refuse to state openly, but admit to themselves.

A comment may be made at this point. In the first place, he uses the term "repression" in two senses: first, as that which is excluded from consciousness and, second, as the process by which the exclusion takes place. The effect of this confusion is to vitiate his argument at the outset. The folly of arguing that the demonstration of a primitive tendency involves an obligation for its direct expression can best be shown by analogy. Man goes through a gill phase in his embryological development; the gill arches are transformed into the lower jaw, the internal bones of the ear, the larynx, etc. In pathological conditions the primitive gill structures may tend to assert their original form. Are we, therefore, untrue to our "real" nature when we use our gill arches to chew, speak, and hear? The dilemma he presents is an artificial one. Our real selves—if one is to use the term at all—are what we happen to be at any point of evolution, whether the development be individual or racial.

The book is written in an effort to escape from this fancied dilemma. He quotes Burrow to the effect that *knowledge* of sex is sin, not sex itself (an argument based on the Adam and Eve story). This gives him a loophole. The incest motive may not be a true unconscious impulse, but only a formulation of it in a specific idea. The impulse could then be moral, although its ideational incorporation were immoral. Without this incorporation in an idea, there could be no knowledge and hence no sin. His explanation of the Œdipus complex is that a man has sex passion all of which he cannot transfer to his wife; he also loves his mother. The solution of the problem of disposal of the excess passion is in incest with the mother, or at least the idea of incest. This is an example of "idealism"—i. e., "the motivizing of the great affective sources by means of ideas mentally derived". When the idea is a fixed motive, it becomes a mechanical principle. Therefore, "pure idealism is identical with pure materialism. . . . The ideal is but the god in the machine—the little fixed machine principle which works the human psyche automatically." "Incest is the logical conclusion of our ideals, when the ideals have to be carried into passional effect."

These startling conclusions are based on more illogicality. No student of the unconscious, with the exception of Lawrence, has ever found the incest fantasy to be a development of marriage or any other adult sex situation. It precedes and is a stage in the development of psychosexuality. The problem invariably revealed in any

case of abnormal psychosexual development is concerned with the failure to transfer to the wife, or other adult object, the interest first felt for the mother. We know, further, that the sex passion for a wife is a conscious affair associated with an actual situation, while the incest idea is an unconscious fantasy. But, throughout, Lawrence fails to discriminate properly between consciousness and unconsciousness. A second error lies in his juggling with words. An "ideal" may not be incorporated in definite ideas at all, but may be quite a vague, instinctive thing. This destroys the lovely paradox of idealism being the same as materialism.

Since incest is the logical conclusion of our ideals, he proceeds, the only way to avoid such disastrous effects is to go back to the *true* unconscious. So far his arguments have been based on logical errors that many untrained writers have fallen into, the criticism of which may be useful. But the rest of his book is purely mystical. In scientific thinking observations are made of external phenomena. Generalizations are constructed to correlate the facts, while fresh observations serve to confirm the theories advanced or else, if they conflict, the theories are modified to suit new facts. The processes of mystical thinking are different. The point of departure is not an objective fact, but a subjective feeling or internally elaborated conviction. On this a more or less logical superstructure is built which corresponds to the scientific hypothesis and may, indeed, be equally logical in its building. The second difference appears in the attitude toward new facts. If they fit the mystical theory, well and good. But if they controvert it, the meaning of the facts is destroyed until they can be warped to fit the preordained scheme. The "truth" of the original feeling is held to be superior to objective observation. The tendency to mystical thinking seems to be inherent in the human mind and, sad to say, many "scientific" theories are really mystical or are vitiated by a mystical element. The advance of science has been achieved by progressive exclusion of more and more mysticism from our thought processes. Of course science has no right to claim that its methods are the only ones by which knowledge is to be gained —that claim will be justified only when everything is understood and no unexplained phenomena occur. But science has the right to protest against mysticism, which is now unpopular as such, parading as science. It will be unnecessary to point the reader's attention specifically to the mystical elements in the following argument:

Life—that is, individual life—begins with the first unicellular organism. With this is the beginning of "consciousness" [he means "mentation", for he uses "consciousness" as awareness elsewhere]

and of the unconscious. Characteristics of individuals, as individuals, are not traceable to those of the parents. The origin of individual life is, therefore, causeless so far as science goes. This life is really the soul. So religion is right and science is wrong. The unconscious is the soul; intrinsically the unconscious is beyond cause and effect, yet follows the laws of cause and effect in its self-realization. Progress is to be obtained by freeing the unconscious from its ideal [he means ideational] superstructure, thereby giving its creative tendency a chance. [This seems to be an echo of Jung's view.]

So far these speculations are harmless enough, being vague, unfocused generalities. In order to work with anything it has to be made tangible, and Lawrence therefore embarks in quest of biological and psychological incorporations of this view and immediately finds himself sailing the chartless sea of pure mysticism. He tries to formulate that which he says is beyond cause and effect in terms of cause and effect. The following nonsense is the result of this effort:

Individual life, consciousness, which is the unconscious, begins at the moment of fertilization of the ovule. The fused nucleus "remains the creative and productive center, the quick, both of consciousness and of organic development". It lies beneath the navel of the fœtus and persists there after birth and throughout life as the solar plexus. This is in the front of the abdomen beneath the navel [anatomists will be glad to learn]. We know it is there because we feel it when we are emotionally stirred; also because new-born mammals and babies, like ventriloquists, cry from the stomach. The solar plexus directs the infant to the mother's breast. [Lawrence seems ignorant of the fact that no new-born infant can find the breast without assistance.] This is evidence of unity with the mother which emanates from this center. The next phase in development is the establishment of individuality. The baby has tantrums and kicks, which is a rebellious protest of individuality. The action proceeds from "the great ganglion of the spinal system, the lumbar ganglion", which "negatively polarizes the solar plexus". The lumbar ganglion of the mother responds when she is irritated by the child's tantrums. These two polarities—unity and protest—make "the powerful pristine subjectivity of the unconscious on its first plane . . ." The polarities produce the union of love and instinctive separation psychologically, while physically these are represented by sucking and excretion. The description of the tender emotions stirred in the mother by the child's urination is touching!

The diaphragm divides the body physically as well as organically. Above it develop two centers of objectivity, still belonging to the

unconscious. The sympathetic plexus of the breast is the heart's mind—the cardiac plexus. Proof of this is "knowing in the heart", which Lawrence, like the ancients, does not regard as mere metaphor. The cardiac plexus above corresponds to the solar plexus below. The child on the mother's breast is seeking knowledge of her. The nipples in both sexes serve "as poles of vital *conscious* effluence and connection". "We do not know how the nipples of the breast are as fountains leaping into the universe, or as little lamps irradiating the contiguous world to the soul in quest." From the cardiac sympathetic plexus streams devotional love. The other upper center is the "strong thoracic center of the shoulders" [unknown to anatomists]. From it goes "a strong rejective force, a force which, pressing upon the object of attention, in the mode of separation, succeeds in transferring to itself the impression of the object to which it has been attached. This is the other half of devotional love—perfect knowledge of the beloved." The two upper centers are separated from the two lower ones by a horizontal line—the diaphragm. But each pair is also divided into front and back, so there is a vertical line as well. The vertical and horizontal lines "form the cross of all existence and being", which, he hastens to say, is not mysticism. There are four great polarities, and for proper development of the true unconscious all four must be exercised. Since they all operate in relation with another person, it is also necessary for this development that there be another individual with whose four polarities association may be established.

The brain is merely a terminal instrument of the dynamic unconscious. "It transmutes what is a creative flux into a certain fixed cypher." The cypher takes the form of ideas. These are static, unproductive; creation and progress come from the creative centers of the abdomen and chest.

Will is the faculty for self-determination. It prevents the preponderance of the intellect over the true unconscious. [He fails to give any anatomic localization for the will as for the other faculties.] The identification of the will with the mind leads to madness, because what should be an instrument becomes an end in itself. So we are left with the alarming conclusion that conscious, intellectual control of our lives is really madness! Lawrence assures us that we should avoid this and strive for a fuller development of the unconscious.

The above is a logically arranged digest of what the author presents disjointedly and with florid discursiveness. The text is still more irrational than what is here presented. Lawrence plainly intends to be understood literally, yet, to be charitable, we might assume that

he is using anatomical and physiological symbols for the expression of psychological concepts. If this were the case, he has outlined the development of what Burrow has termed the "primary subjective state" and its relationship to the objectivated mental processes which we are accustomed to regard as including all mentation. This is a concept psychologically tenable and of high pragmatic value. But Burrow has elucidated this theory in scientific terms, making it applicable for the solution of clinical problems, while Lawrence has obfuscated it in a mystical fog.

JOHN T. MACCURDY.
Psychiatric Clinic, Cornell Medical School.

QUICKSANDS OF YOUTH. By Franklin Chase Hoyt. New York: Charles Scribner's Sons, 1921. 241 p.

Out of the richness of his experience, Chief Justice Hoyt has written this book which tells the stories of boys and girls who have appeared in his court. It is very specifically stated that there is no effort to write a manual on juvenile-court work in general and that the stories included are highly selected. Certain problems are passed over for definite reasons—some because their presentation would involve too lengthy a discussion of the administrative aspect of the juvenile court, some because they would fail to awaken popular interest. "Nor has any but the most superficial reference been made to those two stupendous problems, sex and mental deficiency, which underlie so many of our cases." These, the author believes, deserve much more intensive study and are hardly suited for a "book of sketches dedicated to the reading public".

Undoubtedly the general reading public will find these stories full of interest. There is the story of the gang boy and the genesis of his "Crooking Club". There is the lad who falls in with bad companions and enters into their desperately bad mode of life. There is, too, the immigrant youth who becomes antisocial because he does not understand the ideals of America. Then there appears the runaway in search of adventure, actuated sometimes by the loftiest of motives, sometimes seeking only excitement and novelty, or perhaps only endeavoring to escape from supposedly—or even possibly truly—tyrannical parents. Again there is the adolescent girl who resents home authority, who, sometimes justly and sometimes unjustly, feels herself misunderstood and unappreciated.

Occasionally a slightly more subtle problem, such, for example, as that of the pathological liar, offers material for an interesting tale. There are stories full of humor, stories of pathos, stories of neglected children where the parents are the true culprits, all told well, with all the skill of the story writer.

One is glad that in the first chapter Chief Justice Hoyt subscribes himself as a believer in the services of the expert—the physician, psychiatrist, and psychologist. True, in the body of the book one obtains no glimpse of their usefulness or helpfulness. The judge alone, through his great knowledge of children, his tact and sympathy, obtains the truth, discovers the motive, solves the problem. Unfortunately, experience has taught the reviewer that not all the problems appearing in the juvenile court are so readily understood. The underlying springs of misconduct are frequently unearthed only after many hours of earnest study. Indeed, until the facts gleaned by physician, psychologist, and sociologist are brought together and interpreted fairly, reliable knowledge of causations and fairly adequate notions of treatment cannot be reached.

To those judges and workers in children's courts not so intelligent, far-seeing, and resourceful as Chief Justice Hoyt, this book will probably suggest much. To the average lay reader, it will offer a group of stories interesting in and of themselves, purely as stories.

Augusta F. Bronner.

Judge Baker Foundation.

The Experiences of an Asylum Doctor, with Suggestions for Asylum and Lunacy Law Reform. By Montagu Lomax, M.R.C.S. London: George Allen and Unwin, Ltd., 1921. 255 p.

This work is a criticism, or, to use the author's words, "an exposure of the system of asylum administration" in England. It is based on the experience of a retired general practitioner who was too old for active military duties during the war, but who, wishing to do his bit for his country, served as an assistant medical officer in one large county asylum for two months and in another for nearly two years. In the introduction he states that "it has not been thought necessary to refer to the two asylums mentioned in this book by name". It is interesting to note that he had not occupied his position "more than a few months before it became evident" to him that the administrative system in vogue "permitted the occurrence of grave defects and abuses". He felt that the only remedy for these abuses was in a direct appeal to the public, although his criticisms were never submitted to the administrative bodies responsible for the conditions in question.

He admits that it is "a somewhat ambitious and hazardous undertaking to criticize so vast and complex a system as our lunacy legislation . . . the product during at least two centuries of the most acute and learned legal minds", although he does so without any hesitancy whatever. His sweeping condemnation includes the board

of control, the visiting committees, the medical superintendent, the medical officers generally, and the employees of the hospitals. "One of the chief defects in our system of asylum government against which I protest is that it permits the superintendent of an asylum to combine in his own person the dual offices of medical superintendent and executive chief." He is of the opinion that the steward of a hospital should not be responsible in any way to the superintendent or come under his jurisdiction.

To the American reader it seems strange to see so many references to "asylums", "lunacy", and "lunaties". In his discussion *Wards and General Routine*, he refers to "the victims of fixed 'delusions', the commonest of all forms of insanity, and one that accounts for an eighth part of all inmates of asylums". It is hard to believe that the punishments inflicted on patients in British hospitals are so general as Lomax seems to think they are. The extensive use of croton oil, which he refers to as a punitive measure, seems incredible. The so-called "behind-the-table" treatment of unruly and refractory patients is one that is unknown in this country and has never been noted before in the literature of British psychiatry by the reviewer. Quadrangles, often referred to as airing courts, are apparently what the author speaks of as "pens". Single rooms are often referred to as "cells". It does not seem surprising that in an institution of three thousand patients there should have been eighty deaths from influenza in a period of three months during the pandemic of 1918.

The author does not favor having the patients' mail opened by medical officers and insists vigorously on the necessity of letter boxes for the use of patients in every ward of the hospital. He objects to the "asylum garb", the barracklike buildings, and the dietary in use. It is interesting to know that a hospital for three thousand or more patients can be prepared for a visit by the commissioners, although only "an hour or two's warning is generally forthcoming". That could not be done here. It is surprising to learn that a British asylum has to have a "closet-barrow gang" to clean out earth closets on a hospital farm, although this is a class of labor which the author says "is common enough in various parts of the country". He objects strenuously to wasting so much time in writing case records, which he seems to think of little value and not often read. The refusal of the British authorities to recognize the National Asylum Workers' Union he speaks of as "shortsighted and antiquated opposition to the progressive tendencies of the age". The statement that "in few public asylums is there even an operating table or a proper assortment of surgical instruments" is certainly startling.

American psychiatrists would favor his recommendation to abolish the use of the words lunatic and lunacy in the insanity laws. They

would also agree with him as to the necessity of taking steps for the recognition and treatment of incipient mental diseases. There is room for some difference of opinion as to whether the superintendent and other medical officers should be required to have a diploma in psychological medicine. The recommendation that there should be no distinctive clothing for patients would meet with favor in this country. The necessity of having visiting surgeons and hospital dentists would not be questioned here. It is interesting to note that as ideal asylums he points to the Alt Scherbitz near Leipsic and the "mental hospital" at Toledo, Ohio.

James V. May.

Boston State Hospital.

Dream Psychology, Psychoanalysis for Beginners. By Professor Dr. Sigmund Freud, with an introduction by André Tridon. New York: James A. McCann Company, 1921. 237 p.

It may be stated at the outset that this book does not deserve to be read if one is looking for anything new concerning dream psychology. But it is not so easy to determine the real source of the volume, which, by its title and other implications, purports to be a new or separate book by Freud to which Tridon has been invited to write an introduction. To one who is acquainted with Freud's writings in the original as well as in the English translations, it must seem that, aside from Tridon's introduction, the book consists of reproductions from former English translations of Freud's writings on dreams. The publishers of the book must have been aware of this, judging by the imprint: "Copyright Introduction 1921, by the James A. McCann Company". That the farce of foisting a book of this nature on an unsuspecting public has its serious side is due to the fact that these vendors of Freud's ideas do not confine themselves to "publicity work", but also engage in the treatment and guidance of a most helpless class of sick people, the mentally disordered.

Bernard Glueck.

New York School of Social Work.

Outwitting Our Nerves. By Josephine A. Jackson, M.D., and Helen M. Salisbury. New York: The Century Company, 1921. 392 p.

This book consists of two rather sharply contrasted parts. The first portion is a description of the theories of Freud and his disciples, the second quite obviously an outline of the psychotherapeutic methods of DuBois.

The book is ostensibly intended for lay reading; therefore, the questions that naturally present themselves are the following:

1. Is it an accurate account of the present conception of the nature and treatment of functional nervous disorders?

2. Is it written in such style that it can be assimilated by a person who has no professional knowledge of the subject?

3. Is it a book that can be read by a nervous patient with profit to himself?

In regard to the first two questions, one cannot but be impressed with the very clever manner in which the psychoanalytic method is outlined. To be sure, it is Freudism in "sugar-coated" form, but the subject is evolved simply and logically and in a manner that should go far to convince the lay reader of the tremendous influence exerted by the emotional life on health and behavior.

From the remainder of the book it is quite evident that the authors are faithful disciples of DuBois, in whose methods they apparently place their chief reliance in the treatment of patients. The principle of treatment by persuasion is the outstanding feature in all the case records quoted, though there is a striking paucity of detail in the description of DuBois' methods. For example, the layman is not likely to understand the rationale of such treatment as: "I gave him a poke and told him to dress for dinner."

As for the third question, I am not sure that the book in its entirety could be profitably entrusted to the average nervous patient. The portion dealing with the psychoanalytic school is an excellent primer—an introduction for the patient upon whom a partial or complete analysis is contemplated. The chapters on reëducation, persuasion, and moral hygiene, however, present difficulties that would make one hesitate to employ them in the treatment of a patient, for, as already stated, many of the case records are not convincing. One is apt to be skeptical in the case of the prospective mother who, having some apprehension about her approaching labor, talked to one of the authors for a few minutes and then went home and had her baby without pain. These case records are poured out in such profusion that they savor strongly of patent-medicine testimonials. In this connection, it is a pity that the authors did not take seriously their own criticism instead of offering their case records with an apology. On the other hand, certain of these chapters are exceptionally well done. For example, *Dietary Taboos*, *The Bugaboo of Constipation*, and *Insomnia* all contain a great deal of common-sense argument that we, as physicians, might profitably employ more frequently in the treatment of our patients, particularly the neurotics.

This is not the place to discuss the merits of the DuBois school. We all consciously or unconsciously make use of its principles, perhaps more often than we believe. In reading the phenomenal suc-

cesses presented by the authors, one is forcibly reminded of the well-established criticism of DuBois—namely, that his results are obtained not by reëducation and persuasion, but by suggestion. It is only unfortunate that this part of the book could not have been written in a more convincing manner.

HARRY N. KERNS.

U. S. Military Academy, West Point.

MIND-ENERGY; LECTURES AND ESSAYS. By Henry Bergson. Translated by H. Wildon Carr. New York: Henry Holt and Company, 1920. 262 p.

Whatever one may think of Bergson's vitalistic theory, a new book by him is a philosophical and literary event. Probably no other thinker has so thoroughly steeped himself in the profoundest presupposition of the age—the doctrine of evolution—and certainly no other has been able to exploit that doctrine in like manner in the interest of moral and religious idealisms. When in the latter part of the seventeenth century it was no longer possible to close one's eyes to the fact that a new world had been established by science, a vigorous movement soon developed to turn the new discoveries to the account of religion and morals. Natural theologies, proving the being and attributes of God from the study of nature, issued from the press in great numbers. An analogous activity followed the triumph of the theory of evolution. Bergson has given classic expression to the latter movement, as Paley did to the former. To be sure, Paley "crammed" for his task and Bergson has assimilated his science, with the consequence that the latter does not attempt to validate, as did the former, the common man's concept of God, but rather to defend his abstract right to believe in a spiritual order.

Mind-Energy, then, like Bergson's former books, is a vindication of the "higher life" in the face of science. It is a collection of seven occasional essays on such topics as the relation of life and consciousness, the function of the body in the life of the soul, psychic research, dreams, etc. In these essays Bergson reargues the doctrines for which he is well known. Reality is akin to what man meets in his own living consciousness. I say living consciousness, because, according to Bergson, we are habitually mistaking symbolic representations of consciousness for consciousness itself, as, in the case of thinking, we confuse concrete, living thought with "an artificial imitation of it obtained by putting together images and ideas". Images and ideas are halts of thought. They arise when thinking has made a pause and reflected on itself. What thinking is like when it is in process, that is what reality, the vital *élan*, God, is like.

This ultimate reality manifests itself in two ways: as duration, time, activity, and as matter, space, number. In the one the parts interpenetrate, in the other they lie side by side. That is why (among other things) mathematical science is final in the study of matter and inapplicable in the study of life.

The history of the universe is the struggle of the vital *élan* to insert itself into matter and thereby realize its purpose. What is this purpose? And whence this obstructing matter? Here, possibly, Bergson is advancing to a new stage, a stage reminiscent of Emerson's Over-Soul. The end of life's striving is the creation of a moral personality. But this necessitates individual beings and obstructions. And matter supplies both. "Matter is primarily what brings division" and matter calls forth effort. "Thought which is only thought, the work of art which is only conceived, the poem which is no more than a dream, as yet cost nothing in toil; it is the material realization of the poem in words, of the artistic conception in statue or picture, which demands effort. The effort is toilsome, but also it is precious, more precious even than the work which it produces, because, thanks to it, one has drawn out from the self more than it had already, we are raised above ourselves. This effort was impossible without matter." The aim of life was creation, and this was possible only through the medium of matter at once resistant and pliable. And the highest form of creation is the moral individual. "The men of moral grandeur, particularly those whose inventive and simple heroism has opened new paths to virtue, are revealers of metaphysical truth. Although they are the culminating point of evolution, yet they are nearest the source and they enable us to perceive the impulsion which comes from the deep. It is in studying these great lives, in striving to experience sympathetically what they experience, that we may penetrate by an act of intuition to the life principle itself."

The seven essays illustrate the central truth in various ways. If one remains unconvinced after reading the book, it may be for various reasons. One may find it impossible to make the assumptions Bergson makes; for example, that since man arrived and survived on this planet he was aimed at by the vital *élan*. We have been here so short a time, and are so ineurably biased in our own favor, that we can hardly be trusted to pass judgment on the question. Or one may object to the author's tendency, at critical places, to substitute an account of the way things might have happened (in view of a certain visualization of facts) for a proof that they did so happen. And even while admiring the figures of speech that grace the pages of Bergson as of few, if any, other philosophic writer, one may suspect that they not only serve in that legitimate capacity, but frequently

carry the burden of the argument. Bergson would be more readily appraised if there were a code translation for metaphors.

All in all, *Mind-Energy* may be recommended as a very readable introduction to the author's views. One cannot read it, I think, without feeling oneself in the presence of a man of great ability, sincerity, and originality of expression. And if he does nothing more, he will at least shake one's belief that the mind-body relation has been solved. For readers of MENTAL HYGIENE perhaps the chapters of most direct interest are the ones on *Dreams, The Soul and the Body,* and *Brain and Thought.* The whole Bergsonian literature should be of importance, especially if the translator is correct in his suggestion that "the philosophical problem before us to-day, if we accept the new concept, is to explain the nature and genesis of the unconscious".

M. C. OTTO.

University of Wisconsin.

BERGSON AND FUTURE PHILOSOPHY: AN ESSAY ON THE SCOPE OF INTELLIGENCE. By George Rostrevor. London: The Macmillan Company, Ltd., 1921. 152 p.

There is one kind of book that is very rare. From most books—even good books—the reader carries away little beyond a vague impression. It is a more uncommon book from which he detaches ideas or expressions serviceable as more or less permanent intellectual tools. But the book I mean belongs to a higher category still. It is one that feeds the very tissue of the reader's thought by a sort of mental osmosis—having read which he finds it impossible to be certain exactly what his views were on the subject dealt with in the book before he read it. That is the vital kind of book I believe George Rostrevor to have written in this instance.

I admit that I was not in the least prepared for this. I knew the author to be a poet writing on a theme that tempts to vagueness and occultism. What I expected—an expectation born of experience—was a new variety of emotionalism and a new variation on obscurantist phraseology. Instead, here was obvious loyalty to intellectual standards; here were vigorous logic and a clear, simple, direct style. Quite as obvious was a wider and richer and more normal contact with life than philosophic writings in general show.

The book is a small one, less than 150 pages, omitting a short appendix. For all that, it deals in a fresh manner with a large theme—the nature of life, and how the real nature of life may be known. Rostrevor takes his start from Bergson's argument for the reality of duration or time; from the fact that our experiences are not laid down

in juxtaposition, but interpenetrate. He feels, as many of us do, that we are apt to be run off our feet by the dazzling successes of analytical science, and hence to visualize the universe, including life, as a congeries of discreet particles moving according to mathematical laws.

"Nothing can be accounted for entirely", Rostrevor contends, "and life itself can be accounted for very little, if we fail to recognize the reality and the true nature of time."

"The reality of time", he writes in a very quotable paragraph, "is indeed the first principle of Bergsonian metaphysics. It is essential to the nature of life that it endures, that its moments interpenetrate, that it prolongs the past into the present. The more deeply we live, the more do we realize experience as a unique indivisible flow, with none of its moments wholly separate and distinct. The first 'moment' so-called does not die, to give place to the second; it flows into the second moment, and the second moment so enriched flows into the third. The moments make a growing organic unity, in the same way as notes of music, to an attentive and understanding listener, are bound up inseparably in the process of the tune. This is real time or 'duration'. We may of course relax our activity or attention: then the moments of our life and the notes of the music will be less perfectly fused—our experience will be fragmentary, superficial." Experience in that case may be represented as a series of isolated sensations, emotions, mental states.

"This differing intensity of our experience", he goes on to say, "is the key to the problem of matter and spirit. Matter *at its ideal limit* has no duration: it dies and is born again unceasingly. Its moments are external to one another. . . . Between this purely ideal limit of inertia and the most intense life that we can imagine are innumerable actual gradations. . . . When, therefore, we look out on the world and in on ourselves, the fundamental distinctions we must make are in terms of time, according to differences of tension or rhythm. We must rid ourselves of the notion of time as something one and the same for all. There is one time for unorganized matter—a feeble, evanescent duration, whose infinitesimal pulsations are almost wholly external to one another. There is another duration peculiar to each of the multitudinous forms of life, vegetable or animal. All these several durations form a series, exhibiting a gradual advance in that organization of time by which the past penetrates more and more into the present. Real time is not an even flow; it is individual time, it is one with life, and is infinitely variable."

So far Rostrevor goes with Bergson. The latter's principle of duration, he feels, will stand firm as the great gift of the French

philosopher to future thinkers. In the Bergsonian theory, however, real time is apprehended by a special faculty, a non-intellectual intuition. Rostrevor shows how the attempt to base a theory of knowledge upon a non-intellectual foundation ends in confusion, and urges as more tenable, in the light of the facts, a theory in which the apprehension of duration is arrived at through an extension of the scope and power of everyday reflection. All we need to do is to overcome the analytical habit of the intellect, and this can be done by reflection on our memories. "Awareness of its self as enduring in time is always an awareness of the past: it may, however, be an awareness of the immediate past which is strong and vivid in the memory, and which does not require any effort to recall it: and if we direct our attention to the fugitive moments when we begin to pass from absorption in some activity to reflection upon it, we may get a glimpse of the enduring essence of that activity before the natural tendency of our intellect has been able to arrest its flow and decompose it into elements. In these moments of transition the intellect has only just commenced to come into operation. Nevertheless, it is the intellect alone which obtains the vision. *The difference between this intuition by reflection on the immediate past and intuition by reflection on more distant memories is simply that in the former case we can grasp the truth before it has been spoilt by analysis, while in the latter we have to reject the interpretation which analysis presses upon us; we have to undo the way of analysis.*"

Having hit upon what he regards as an intellectual proof of the existence of a form of reality disregarded by mathematical science, the author applies the same method to the alleged "escape of the individual from the prison of the separate self and his mergence in a life greater than his own". The intuition of the mystic remains intellectual: it is his experience that differs from the average. "If intuition", writes Rostrevor, "is to reach out beyond our individual selves to a higher level of reality, it will not be by the penetration of our *minds* into a reality outside us, but by the mergence of our *whole being* in a greater whole." Necessarily, however, there will be a return to the individual life, to the senses, the intellect. "In the rapid transition consciousness will begin to awake and to reveal to him the nature of the life with which he has been identified. The transition, however swift, can hardly be entirely abrupt: in the moment when the mind is most nearly in contact with the overwhelming experience, it is possible that there may come a sudden, vague, fleeting vision—an intuition of the greater, the universal self. As the transition continues, the intellect comes more fully into play, and the

vision breaks up into units of imagery, growing clearer, but losing touch with the original. After this point is reached, mystical experience can only be apprehended by reflection upon it, as upon any other memory."

The quotations I have given do not, of course, convey the full force of Rostrevor's argument. They do, perhaps, give a fair idea of the scheme of the book. Its chief value, in my judgment, lies in the attempt to show the inadequacy of mechanistic science by the use of the same intellectual means employed by the mechanist himself—namely, the mind. I have long been convinced that no so-called transcendent faculty holds out any hope, and no pure mystic that I know of has shown enough faith in mystical intuition to adhere to it consistently. On the other hand, the mechanists have been equally inconsistent. They have constant recourse to terms and concepts that have no place in a mechanistic universe of discourse. The author of *Bergson and Future Philosophy*, therefore, deserves much credit for his vigorous attempt to rid the subject of ambiguity. Whether he has logically demonstrated the soundness of his thesis regarding the nature of ultimate reality is for the moment less important. To my mind, the demonstration must remain inconclusive as long as the author of it assumes, as it seems he does, that the intellect is an entity, and that life, not actualized in any individual thing, yet aims and purposes. But at all events, the book presents an able, informed, clean-cut argument, charmingly written, for the proposition that we may logically show reality to be a growing, increasing thing, "so that there is more reality now than when the human race first appeared on earth, and more reality to-day than there was twenty-four hours ago". The importance of this proposition, if true, it would be difficult to exaggerate.

M. C. Otto.

University of Wisconsin.

Lectures on Industrial Psychology. By Bernard Muscio. Second edition (revised). New York: E. P. Dutton and Company, 1920. 300 p.

Human Engineering. By Eugene Wera. New York: D. Appleton and Company, 1921. 378 p.

The second edition of Muscio's lectures originally delivered at the University of Sydney, New South Wales, is particularly welcome because it is one of the most satisfactory presentations yet published of the scientific problems involved in the subject. It is not, however, an extensive treatise on industrial management; its purpose is rather

to suggest ways in which psychological knowledge may be utilized. These the author outlines in the first chapter as aid (1) in selecting workers on a basis of natural fitness, and (2) in constructing good methods of work for the purpose of obtaining from any expenditure of human energy or effort a maximum production.

There follows an analysis of the difference between the principle of "speeding up"—meaning the effect of increased production through offering workmen rewards of some kind as incentives to greater expenditure of energy—and the principles of scientific industrial psychology, which are commonly confused with the first principle.

Some of the mental factors relevant to industry as it exists to-day are discussed in the second lecture, chief attention being given to fatigue. The author has done extensive work in this field for the British Industrial Fatigue Research Board, an important report by him appearing in the June, 1921, issue of the British *Journal of Psychology*. His treatment here covers briefly the theoretical nature of fatigue, the causative factors of speed, noise, and specialization with tables showing diurnal variation in accidents, output, and errors. His suggestions for lessening fatigue are restricted to the one matter of reducing strain upon attention, which he considers of supreme importance. He recommends (1) the utilization of mechanical arrangements to minimize the necessity of frequent acts of decision, inspection, or competition for operatives, such as a continuous succession of pauses at irregular intervals in the rhythmical movement of the operation; and (2) the introduction of regular pauses to allow for recovery from fatigue. With regard to muscle coördination, he believes that scope should be given for the almost simultaneous exercise of similar muscles and groups of muscles on the two sides of the body. Individual differences in special senses, motor capacity for precision, complexity, and strength, attitude to monotony, and attention type are considered, but not in detail.

In the third lecture the author describes the early experimental attempts at selection of workers on the basis of natural fitness. In these he distinguishes two principles of determining fitness for complicated work: (1) breaking the process into as many distinct parts as possible and testing prospective operatives for each, as in the case of telephone workers; (2) selection by testing for capacity in the central or most important part of the process, as with motormen. Laboratory examinations for all trades are advocated by the author, although the technique of such tests is still in its infancy.

The chapter on scientific management is particularly valuable as a survey of the facts that scientific investigations have brought out concerning the best possible conditions of work; for example, the

greater inimical effect upon efficiency caused by humidity and temperature than by "impure" air, or the detrimental effect of shining surfaces. The modification of actual movements made by workmen, growing out of motion study, is excellently summarized, and the desirability of further applications of psychology to industry is emphasized, notwithstanding the hostile attitude of trade unions toward it. Muscio offers some refutation to labor's arguments that scientific management entails widespread unemployment, destroys individuality, craft skill, freedom, and democracy. The charges that it is responsible for the unfair distribution of extra profits and undue speeding up rest, he shows, on confused thought and insufficient analysis. Two unfortunate emotional reactions appear in the initial stages of scientific management—anger is roused in the workman under pressure of having his work accurately timed, and fear is excited by a sense of lost power and security under scrutiny. For the removal of these disadvantages the author makes the following practical recommendations: (1) instruction of the worker in the underlying principles, (2) gaining of the worker's consent to coöperate in time studies, (3) adoption of a shorter working day because it is proved possible to obtain a given output from a much smaller expenditure of human energy than that hitherto necessary and at a much lower cost in neurasthenia and other affections that prevail in industry where scientific relief measures have not been inaugurated.

In sharp contrast to this work of an experimental psychologist is that of Eugene Wera, an engineer, who writes of the management of human forces in industry with the barest understanding of psychological problems and an apparent ignorance of laboratory or statistical findings.

The first part of his book ambitiously comprises a study of the evolution of the ideas that govern industrial relations as seen in the development of trade unions, labor parties, socialism, and coöperative movements. The treatment is of necessity sketchy, and is wholly inadequate as a summary of the genesis, historical development, and psychological significance of these movements.

The second part, a presentation of recent labor tendencies, is more successful, although scientific interpretation of the dynamics of these tendencies is lacking.

The third part, the author tells us, "gives a brief analysis of the different psychological associations of men involved in industry. Further, it discloses the forces that control human behavior in its relation to industry and shows how to manage these forces." Would that the reviewer could find this revelation therein! Modern psychology seems to have contributed nothing to this discussion. The classification of man's desires is so obsolete as to be almost amusing. The

single quoted authority in the field of applied psychology is Scott. A few generalizations are made to suffice for the subjects of fatigue and conditions of effective work. Furthermore, the author's promise of showing how motives that control the behavior of labor in industry may be turned from antagonism and directed toward coöperation will afford scant interest to students of mental hygiene.

MIRIAM C. GOULD.

Vassar College.

THE PSYCHOLOGY OF EVERYDAY LIFE. By James Drever, M.A., B.Sc., D.Phil. New York: E. P. Dutton and Company, 1921. 164 p.

THE PSYCHOLOGY OF INDUSTRY. By James Drever, M.A., B.Sc., D.Phil. New York: E. P. Dutton and Company, 1921. 141 p.

Two excellent books. The first is not an elementary textbook of psychology, as the author explains in his Preface; neither is it an account of some of the marvels of psychology with all the psychology left out. "It is popular, indeed, in the sense of being intended for the general reader, but from first to last it is a serious attempt to present, as far as possible in non-technical language, the main facts of the science so far as they touch the life of the man in the street." And the author has done this exceedingly well. The topics are well chosen, are discussed clearly, even delightfully. "Everyday life" quite evidently does not mean for the author mere "sensation", "perceiving", and "remembering", but includes such things as "defense mechanisms", "emotional complexes", an " 'unconscious' ", and the like. The psychoanalysts are, of course, the source of the material on these subjects. The book, however, is not and does not pretend to be an exposition of "new psychology", but the author does not hesitate to incorporate, in their proper relation to psychology as a whole, what he considers to be the noteworthy and important contributions of recent investigations. And in so doing he enriches his book and gives it distinction over most of its kind. In an appendix, he has the courage to list "The Hundred Best Books in Psychology". In addition to the names one would expect to find are Adler, Brill, Freud, Hart, Moll, Pfister, Prince, Rivers, Sidis, and White.

The second book is not a contribution to the psychology of industry in the sense of a record of new material, but is a review, and an excellent review, for the man in industry of the work that is being done in the field of industrial psychology and the possibilities and limitations of this work. In the course of a few hours, the secretary of a union, the foreman in the shop, the man at the lathe, or the president of the company can gain, by reading this book, a fairly comprehensive view of what some of the things they have been hearing

about really mean. And they will be interested: the account is well and clearly given. Interested and understanding, they are likely to be sympathetic and coöperative toward further work of this kind.

Librarians who are frequently at a loss how to choose between books that are too heavy and dull and books that are too light and airy, in satisfying the many demands made upon them for books on these subjects, should have their attention called to these two. With a sufficient number of copies of Drever on the shelves, their problem is solved for the present.

Frankwood E. Williams.
The National Committee for Mental Hygiene.

Sex for Parents and Teachers. By Wm. Leland Stowell, M.D. New York: The Macmillan Company, 1921. 204 p.

It is gratifying to find a book of this kind prepared for the use of parents and teachers. We have long recognized the need for a simple, frank discussion of these facts of sex, and many books have been written on sex hygiene, but most of those produced hitherto for the non-scientific reader have either been too involved—and hence have failed to meet the requirement of simplicity—or, in a zealous attempt to settle this problem of sex once and for all, have stressed unduly the religious and moral aspects of it, and have often failed to supply the necessary information about the biology and physiology of sex.

In his little book Dr. Stowell gives scientific information in a very readable, comprehensive manner. To clarify and simplify the material presented, he has included chapters on plant reproduction and on propagation of the species among fishes, birds, and a few of the higher animals. In so doing, he supplies a much needed simple medium for the instruction of children, for it is recognized by all who have contacts with children, either as parents or teachers, that the first and simplest lessons of sex are most easily taught through the obvious illustrations encountered in the everyday life of the child.

The last two-thirds of the book deals with sex in man, and the discussion is all that could be wished for in a book of its kind; the chapters on the anatomy and physiology of male and female are simple, but complete, and the inclusion of a chapter on the ductless glands and hormones links up the psychology of the endocrine systems in a sufficiently comprehensive fashion to clear up much of the scepticism of the uninformed.

The chapter on embryology contains some illustrative plates that should be of much assistance in clarifying this phase of human development in the mind of the reader. The inclusion of chapters on

puberty, heredity, eugenics, and marriage are not amiss in a book written primarily to supply information to parents and teachers.

This book should be highly commended for its simplicity and reliability and should be made available as a simple textbook for all who are seeking a medium of instruction in the matter of this ever-present problem of sex.

Marion E. Kenworthy.

New York School of Social Work.

Practical Psychology and Psychiatry: For Use in Training Schools for Attendants and Nurses and in Medical Classes, and as a Ready Reference for the Practitioner. Fifth edition, revised and enlarged. By C. B. Burr, M.D. Philadelphia: F. A. Davis Company, 1921. 269 p.

If, as the subtitle indicates, this book is to be used in training schools for attendants and nurses and as a ready reference for the general practitioner, it must be useful to the social worker, the lawyer, and the man on the street. It is putting it mildly to say that any psychiatry which can reach the general practitioner can reach anybody. Many will find this book interesting who would not want to read even such a manual of psychiatry as Rosanoff's, whose fifth edition is for the student of mental disorders and for him only.

Wandering through the pages, we find the author, surrounded by his patients, laughing with them and learning from them. We learn what he feels about German character and the up-to-date jazzy American generation, and how he wants to make the modern girl go to the family wash tub and her brother bed down the cows and the horses. To the lucid definitions which sprinkle his pages should be added definitions of such terms as "horse", "spelling down", "work", "swell-body cutter", so that modern youth could begin to find his way back to the lost heaven of the seventies.

The first dozen pages treat of life and the nervous system. The next discuss thinking, emotions, will, in ways that can readily and superficially be understood. How disturbances which we know as symptoms of insanity arise in these elementary processes is the next consideration. Hallucinations, delusions (false beliefs due to disease), memory defects, emotional unbalance, altered will power, are passed in review. The text is clearly arranged and, with sentences numbered in appropriate places, is well adapted for teaching purposes.

Symbolism has a chapter to itself which consists simply in calling attention to the associations tied up in our common language—in implied figures of speech—and how these associations in disease may become the bases of obsessions.

The word "insanity" appears alone at the top of every page from 69 to 192, upon which pages appear an account of the causes and forms of what some would prefer to call the psychoses. The short descriptions are adequate and are interesting in proportion as the patients are allowed to tell their own stories and, with kindly introductions by the author, discuss their own symptoms and the universe—in prose and poetry. Under dementia praecox comes this bit of verse:

BACHELOR LOVE.

Occasionally indulging
In Light Havanuas
And chatting affably
Refreshing Ideas
Precision and Exactness
Of a Bachelor

His mode of living
His accomplishments
His well organized Constitution
His Bashful demeanor

The impediment of his love
It is reckoned as not durable
Is refreshed by a shower
And is extinct in an hour.

Chapters on the medical and nursing management of cases are full of practical suggestions and wise hints. They show that Dr. Burr is often able to put himself in the patient's place. In the nurse he suggests the need of a sense of humor, of a willingness to forego "the last word", and a careful study of why the patient does some discouraging thing. There is often in the patient a willingness to do things if some one else will shoulder the responsibility; often good sound sense can be found in the midst of delusional formation. "The restlessness of mania must have vent." The "laziness" of melancholia is not often to be "braced up". The nurse and psychiatrist, thinking together *for* the patient, may save him from the cruelties unknowingly forced upon him by the family. Getting away from home may mean relief from too high standards—may even substitute a natural homesickness for abnormal fixed ideas.

E. D. BOND.

Pennsylvania Hospital.

NOTES AND COMMENTS

Alabama

The Alabama Home, established by the 1919 legislature and located at Tuscaloosa, will be ready to receive mental defectives in the near future.

Arizona

Chapter 18, Laws of 1921, amends the commitment law relative to a person brought before the judge of the superior court of any county by reason of insanity by providing that he be examined by two physicians instead of one, as formerly.

Senate Concurrent Resolution No. 3, which was approved in March, 1921, authorized that The National Committee for Mental Hygiene be requested to conduct a mental deficiency survey of all state, county, and city institutions, and also the public schools of the state. This survey, which is now in progress, is discussed briefly on page 207.

California

A department of institutions is created by Chapter 610, Laws of 1921. This department is to be conducted by an executive officer known as the director of institutions, to be appointed by the governor. The department of institutions is to have all the powers and duties formerly vested in the boards of management of the Industrial Home for the Adult Blind, of the state hospitals, of the state institutions for mental defectives, of the Industrial Farm for Women, the general superintendent of state hospitals, the state commission in lunacy, the board of trustees of Whittier State School, of the Preston School of Industry, of the California School for Girls, and the state dental surgeon. The offices of general superintendent of state hospitals, state commission in lunacy, and state dental surgeon are abolished. The various boards just mentioned are to continue, but in an advisory capacity solely.

The bill that would provide for the establishment of two psychopathic hospitals, which was summarized in the April, 1921, issue of MENTAL HYGIENE, failed to pass.

Chapter 548, Laws of 1921, changes the name of the Department for Clinical Diagnosis of the Whittier State School and other institu-

tions into the "California Bureau of Juvenile Research". Psychological work and juvenile research conducted at the state schools, the state homes for mental defectives, and other institutions of the state caring for minors are to be under the control of this bureau.

The following appropriations made by the 1921 legislature to the state hospitals are worthy of mention: Norwalk State Hospital, $434,000 for additional construction and equipment of new buildings; Mendocino State Hospital, $150,000 for the erection, equipment, and service in connection with a reception building; Napa State Hospital, $100,000 for construction and equipment of a new cottage for patients; Stockton State Hospital, $150,000 for a reception building. The Pacific Colony, the new state institution for the feebleminded, has been granted $120,000 this year for buildings, improvements, and additional equipment. The Sonoma State Home received $67,500 for the erection of quarters for officers and employees, $71,000 for construction and equipment of cottages for patients, and $100,000 for the erection of a schoolroom and assembly building.

Connecticut

Chapter 110, Laws of 1921, provides that any person who has suddenly become in need of treatment in a hospital for mental diseases, public or private, may be cared for in such hospital for a period not exceeding twenty days without order of any court. At the time of his delivery to the hospital, there must be left with the person in charge a certificate, signed by a reputable physician not more than three days previously, stating that, after a personal examination made within three days prior to the date of the certificate, he is of the opinion that the person is in need of immediate treatment and the reasons therefor. This law repeals a similar one enacted in 1919 in which the period of temporary detention was limited to ten days.

The Connecticut State Hospital, at Middletown, received an appropriation of $325,000 from the 1921 legislature for an acute reception hospital. An additional $90,000 was secured for alterations and repairs on the present buildings.

Delaware

Chapter 160, Laws of 1921, which relates to the establishment, maintenance, and control of the public schools of the state, among other regulations empowers the state board of education to provide for the mental examination of such children as have made no advancement in their studies in three successive years of regular attendance.

District of Columbia

The Underwood Bill, providing for the physical and mental examination of children brought before the Juvenile Court of the District of Columbia, was defeated in the House of Representatives.

Florida

The State Farm for Feebleminded and Epilepties, at Gainesville, authorized in 1919, was opened November 3, 1921.

Georgia

The Georgia Training School for Mental Defectives was recently opened. It is located at Graeewood, about eight miles from Augusta. It is built on the cottage plan, the construction being of concrete, with a farm of about 300 acres. This institution was authorized by the 1919 legislature.

Iowa

Chapter 5, Laws of 1921, authorizes the admission of feebleminded persons to the State Hospital and Colony for Epilepties, whenever the State Institution for Feebleminded Children is overcrowded and the facilities at the latter institution are inadequate to care for those received. Rules governing admission, training, and care are made the same for the two institutions. The law also provides for the transfer of feebleminded persons between the two institutions.

A commission on uniform state laws is created by Chapter 201, Laws of 1921. It is to consist of three members appointed by the governor, each of whom must be a member of the bar and of good standing. The commissioners are to promote uniformity in state laws upon such subjects as may be deemed desirable.

The State Psychopathic Hospital, which was authorized in 1919, has received from the 1921 legislature an appropriation of $97,000, of which $35,000 is for the completion of the building and $62,000 for equipment.

An appropriation of $35,000 for an industrial building at the State Institution for Feebleminded Children has been granted by the 1921 legislature.

Louisiana

The State Colony and Training School, authorized by the 1918 legislature as a state institution for feebleminded and located at Alexandria, opened in December, 1921, with about 40 patients.

Massachusetts

A resolution was approved May 9, 1921, that the commissioner of public welfare, the commissioner of mental diseases, and the commissioner of corrections constitute a commission to investigate the subject of providing suitable quarters for defective delinquents, and report its recommendations to the 1922 legislature early in January.

The Belchertown School for the Feebleminded, authorized by an act of the 1915 legislature, which has been under the supervision of the Wrentham State School during construction, has received from the 1921 legislature an appropriation of $260,400 for new buildings and $10,000 for road work and grading.

New construction and improvements for the Westborough State Hospital are planned which will cost about $600,000.

Michigan

An institution to house and employ subnormal persons is planned in Detroit. Dr. David R. Clark, Psychiatrist of the Detroit Receiving Hospital, will be in charge of the institution. It will be called the Industrial Adjustment Center.

The 1921 legislature granted an appropriation of $140,000 to the Ionia State Hospital for new construction and improvements, with an additional $16,000 for new equipment.

Missouri

The sum of $137,500 was appropriated by the 1921 legislature for new construction at the Missouri Colony for Feebleminded and Epileptics, including a custodial building and additions to the power house.

North Carolina

The contract has been let for a new reception building at the state hospital for mental diseases at Morganton.

Pennsylvania

A department of public welfare has been established by Act No. 425, Laws of 1921. This department is to have supervision over all state institutions, including penal, reformatory, and correctional institutions, hospitals for mental diseases, institutions for the feebleminded and for epileptic persons, for the deaf, for inebriates, for juvenile delinquents; all charitable institutions maintained wholly

or in part by the state, which have formerly been under the jurisdiction of the board of public charities or the committee on lunacy; all county prisons, almshouses, and hospitals maintained by any county, city, borough, township, or poor district of the state; all societies to whose care delinquent, dependent, or neglected children are committed; any place in which persons of unsound mind are detained; and any homes boarding infant children. The chief executive officer of this department is the commissioner of public welfare. The commissioner is authorized to establish certain bureaus, not exceeding four in number, one of which is to be a bureau of mental health, to further the prevention and cure of mental diseases. Dr. William C. Sandy, Psychiatrist of the New York State Commission for Mental Defectives since May, 1919, has been appointed director of the bureau of mental health and assumed duties December 1, 1921.

A law enacted by the 1921 legislature provides for the quarantine and for the detention and treatment at the State Asylum for the Chronic Insane of persons afflicted with syphilis. Any person with syphilis who is a patient of any state hospital for mental diseases or an inmate of an almshouse or poorhouse may be committed or be voluntarily admitted to the state asylum. Any person suffering with syphilis who refuses to go to this institution and who is considered a menace to public health may be quarantined and removed to the state asylum to remain until discharged upon the certificate of the commissioner of health stating that the person has been cured or is no longer considered a menace to the health of the community.

Texas

A mental-hygiene clinic for children is being planned by the health department of Houston.

Wisconsin

The state will construct a $250,000 hospital for ex-service men with mental diseases at Governor's Island, near Mendota. Dr. W. F. Lorenz will be in charge of it.

Wyoming

Chapter 159 of the Laws of 1921 provides that all juvenile delinquents, before commitment to any state institution, besides being examined by a regularly qualified physician, shall also be given a mental examination by the state director of special classes, by the superintendent of the state institution for mental defectives, or by a properly qualified person designated by either.

Prevention of Mental Diseases

From the address of Governor Channing H. Cox to the two branches of the Legislature of Massachusetts, January 4, 1922

The commonwealth has recognized its responsibility for the care and treatment of those suffering from mental diseases and defect, and in the state-hospital system has provided facilities for the treatment of these cases. In most instances, however, only those patients receive treatment who have well-established and rather serious mental symptoms. The majority of those patients are committed to the hospital, and the number who go on a voluntary basis, because they realize the necessity of treatment, is not large.

The great sums expended by the commonwealth for the maintenance of these institutions emphasize the fact that much is to be done in the field of practical mental hygiene to stop the increasing numbers for whom institutional care must otherwise be provided. It is an accepted fact that approximately one-half of all patients admitted to our state institutions are suffering from mental disorders that could have been prevented. Our efforts must be continued to overcome a hesitation to use our state hospitals—a hesitation due in part to ignorance and in part to the continuing effect of old tradition. Every effort must be made to bring treatment to bear upon the early stages of mental disorder, through a continued campaign of education and in trying to promote the best possible conditions in childhood for those who are handicapped either by mental defect or by nervous instability which may later lead to nervous and mental disorders. The commonwealth has recognized the importance of a practical mental-hygiene program, and has provided much legislation to make effective such a program.

The state's program for the feebleminded embraces the following factors:

1. Identification.
2. Registration.
3. Education.
4. Supervision.
5. Segregation.

The establishment of school clinics—the Department of Mental Diseases coöperating with the Department of Education—whereby school children three or more years backward are examined, represents an extraordinary achievement, there being no known similar provision anywhere else in the world. These clinics have been made constructive from the start, the purpose of the examination being not to discredit the backward child in any way, but rather to ascertain

exactly what school progress he is making; to insure that he is not worked beyond his capacity, and that not too much is expected of him; and so far as possible to ascertain any special reasons for his lack of development.

Approximately 3,000 children have been examined since the organization of the clinics in the spring of 1921. The cordial coöperation with which this work has been received is noticeable; both the parents and the school authorities are using results of the examinations to do more for the children than has ever been done before. As a result of this work, specially unstable children may receive adequate supervision and care.

The continuing census of the feebleminded, which the Department of Mental Diseases has under way, has far-reaching possibilities; the regular checking up of the lists will show those defectives who are not capable of community life and also those of the hereditary grade who are likely to propagate their kind and who need institutional segregation. It will also show the well-developed defectives who are conducting themselves properly and who can safely be trusted in the community.

There are now large numbers of feebleminded patients of our schools for the feebleminded living in the community under slight supervision, practically all behaving themselves and the majority supporting themselves. Recent legislation provides definitely for community supervision of the feebleminded, and with provisions for the necessary machinery to carry on this work a much larger number can be cared for in the community, and room made available for those requiring, temporarily at least, institutional care. The schools for the feebleminded should, in the future, function very largely in giving a period of training to large numbers and then return this group to the community to earn their own living. It is interesting to note that a group of 93 from one of our schools for the feebleminded were supervised in the community last year and earned, collectively, $102,000.

There is great need for extension of this principle of community supervision as far as possible instead of expensive institutional support and the large expenditures for the construction of buildings (new construction costs approximately $1,500 per bed; annual maintenance, at least $300 per patient). The importance of the feebleminded problem now warrants the recommendation that there be created with the Department of Mental Diseases a Division for the Feebleminded.

The state-hospital system conducts well-organized out-patient clinics. This work should be continued and encouraged. A practical program in mental hygiene looks forward to coöperating with the courts in the

examination of any one where there is the least suspicion of mental disease or mental defect. This should be encouraged, to the end that all courts having to do with juvenile delinquency could be furnished with a psychiatric report.

The psychopathic hospital provides a unit of the general-hospital type for the reception of early cases of mental disorder. There is a very noticeable tendency to make use of such small units by individuals who, either themselves or their relatives, are unwilling otherwise to use the state hospital. To take advantage of this principle, there is legislation available for the organization of small psychopathic-hospital units.

Massachusetts has gone far in providing care and treatment of the insane and mentally defective. The work is being well done to-day and large appropriations are necessary for its continuance. The only escape from constantly increasing expense lies in the adoption of more preventive measures. I urge the continuance of the support given last year to a program of prevention to offset the growing and increasing demands for institutions to care for those whose mental disorders could have been prevented, and to the development of all means to care for the individual, especially the feebleminded, in the community under supervision rather than the more expensive plan of establishing new hospital facilities.

Southern Branch of National Soldiers' Home to be Used for Cases of Senility

In the letter with which the President of the Board of Managers of the National Home for Disabled Volunteer Soldiers transmitted the annual report for 1921 to Congress, the following reference is made to new provisions for Civil War veterans suffering from mental disorders, which the board feels constitute one of the greatest improvements made in recent years:

"With the course of time, a great many cases of senility have developed among the veterans of the Civil War and the facilities which we had for the care of these men in the different branches of the National Home were naturally inadequate, and we felt that we were not giving the men the care to which they are entitled. However, during the later period of the use of the Southern Branch by the army, it was largely adapted for the use of neuropsychiatric patients and was turned over to the board by the army with a great deal of equipment for the proper care of mental cases. With the equipment ready for this use, the board adopted the plan of transferring from the branches in the East to the Southern Branch all

cases of senility, and the result has been that we are now able to give this class of unfortunate veterans the care to which they are entitled, and the board feels that they have done a worthy act in furnishing these aged men with proper medical attention, nursing, and good surroundings."

The Southern Branch is beautifully situated at Hampton, Virginia, opposite Old Point Comfort, and has long been considered the most attractive of the National Soldiers' homes.

Mental Deficiency Surveys Conducted by The National Committee for Mental Hygiene

During the year 1921, the legislatures of Wisconsin and West Virginia passed acts providing for greatly increased care for the feebleminded. This was the result of surveys made in these two states by the Mental Deficiency Division of The National Committee for Mental Hygiene. In Wisconsin a very large appropriation was made available for new buildings at both of the state institutions for the feebleminded. A mental clinic was provided for the public schools. A state department within the board of control was created to supervise mental defectives out in the community. In West Virginia the state board of control was authorized to create a separate institution for the feebleminded.

During the year 1921, the Mental Deficiency Division of The National Committee for Mental Hygiene has conducted surveys in Maryland, South Carolina, and Cincinnati, Ohio. The Maryland survey has been under the local direction of Dr. Thomas H. Haines. This survey was completed during the month of October and a report with recommendations has been placed in the hands of Governor Albert C. Ritchie. The survey of South Carolina has just been completed and a report is now being made. This study contains a very careful inquiry into the mental condition of all inmates of state and county penal, correctional, and dependent institutions, and a mental-hygiene study of several thousand public-school children. The survey staff is composed of Dr. A. Feldkamp, Psychiatrist; Dr. Frank O'Brien, Psychologist; Miss Mina Sessions, Psychiatric Social Worker; Mr. C. L. Hultgren, Psychologist; Miss Millie Stevens, Psychiatric Social Worker; and Miss Dorothy Horne, Secretarial Assistant. It is expected that this survey will result in greatly improved care of mental defectives in the state. One noteworthy phase of the South Carolina investigation has been a study of the mentality of the negro. Several thousand negro school children, negro college students, and negro delinquents and dependents have been carefully examined.

The Cincinnati survey, a very intensive mental-hygiene study, includes a physical and mental examination of 5,000 public-school children, delinquent individuals coming in contact with courts and correctional institutions, dependents in institutions and in contact with relief agencies, cases of unemployment, illegitimacy, venereal disease, and other social problems. The Cincinnati mental-hygiene staff is composed of Dr. C. Leonard, Psychiatrist; Dr. Rose Dintzess, Psychiatrist; Mr. Frank Fearing, Psychologist; Miss Bertha Allen, Psychologist; Mrs. Flora May Fearing, Psychiatric Social Worker; Miss Marguerite Reed, Psychiatric Social Worker; Miss Mary Schmidt, Psychiatric Social Worker; Miss Laughad, Psychiatric Social Worker; and Miss Margaret Cavender, Secretarial Assistant. A large number of social workers have volunteered their services in connection with this survey. The state board of health entered wholeheartedly into the survey and contributed to the physical examination of school children. The vocational bureau of the public schools coöperated and furnished most valuable assistance. Two special phases of the work here deserve attention—the physical study of public-school children in order to determine the relationship of physical factors to mental conditions, and a social investigation of all problem cases in order to determine the background, history of past careers, heredity, home environment, and the like. A report of this survey with recommendations will be completed during the month of January. As a result of the Cincinnati survey, officials of the university, social agencies, courts, and various business men are already planning to create and maintain a psychopathic hospital with a psychiatric clinic for this city. It is planned that the director of the clinic will be professor of psychiatry in the university.

During the year 1922, the Mental Deficiency Division of The National Committee for Mental Hygiene will undertake a mental-hygiene survey of the city of Louisville and state surveys of Arizona, Arkansas, Wyoming, and North Dakota. The survey of Louisville is noteworthy because of the unusual coöperation promised by state and city boards of health, social agencies, courts, and others in this city. The state board of health, in coöperation with the Louisville Mental Hygiene Society, has planned a course of mental-hygiene lectures to cover a period of three weeks as an introduction to the survey in order to inform the general public of the problems to be dealt with along these lines. Dr. Frankwood E. Williams has been asked to initiate the course. The survey of Arizona is already under way, and in connection with the general study a special investigation will be made of the mentality of Indians. Dr. Thomas H. Haines, who is directing this survey, has already begun work in Phoenix.

Psychiatric Service to Juvenile Courts

Through a special gift from the Commonwealth Fund, as a part of its program for the study of methods for preventing juvenile delinquency, The National Committee for Mental Hygiene has been able to create a new department to be known as the Division on the Prevention of Delinquency. One of this division's activities will be to furnish, free or on a cost-sharing basis, psychiatric service to a limited number of juvenile courts throughout the country upon request. To each court in which it will be possible to render such aid will be assigned for a specified period a demonstration clinic staffed by a psychiatrist, a psychologist, and a psychiatric social worker. This clinic will not only conduct careful studies of individual delinquents, but will demonstrate what can be done in the way of treatment and social adjustment for each child. The assignment of a clinic to a city will depend largely upon the interest manifested by those concerned in dealing with juvenile delinquency and the prospects of there being established and maintained at the expense of the community a permanent court psychiatric clinic.

The establishment of this psychiatric field service will make it possible to supply to juvenile courts and probation officers in the United States a means of becoming acquainted at first hand with the practical value of psychiatric work in the management of juvenile delinquency and will assist them in organizing such work on a permanent and scientific basis.

Another aspect of the work of this division will be to undertake inquiries covering a period of several years that will deal with the prevention of delinquency in a special population group. Monmouth County, New Jersey, has been chosen for the first experiment. Here an extraordinary opportunity presents itself to study the school children of a county, and to put into effect measures looking towards the prevention of juvenile delinquency.

The work will be conducted in coöperation with a general program in child welfare, health, and education. We believe this will furnish an unusually favorable opportunity for conducting field studies in juvenile delinquency in which the practical work of treatment and prevention can be combined with medical and social research.

It is expected that opportunities to conduct work of a similar kind will present themselves from time to time in other parts of the country.

The Division on the Prevention of Delinquency will also maintain a clearing house for information and advice, and will carry on studies of the laws and facilities of various states and cities throughout the country, in order that reliable and authoritative information may be

obtained regarding matters dealing with delinquency and its prevention.

Dr. V. V. Anderson, who is Director of the new Division on the Prevention of Delinquency, will be in immediate charge of all work undertaken by the division, but will be assisted by an advisory committee. The following persons have already accepted membership on the committee: Dr. Thomas W. Salmon, Medical Advisor of The National Committee for Mental Hygiene, Chairman; Hon. Charles W. Hoffman, Judge of Division of Domestic Relations of Hamilton County Court of Common Pleas, Cincinnati; Miss Emma O. Lundberg, in charge of Social Service Division of Children's Bureau, Washington; Mr. Herbert C. Parsons, Deputy Commissioner of the Commission on Probation, Boston; Dr. Walter E. Fernald, Superintendent of the Massachusetts School for the Feebleminded, Waverley; and Dr. Lewellys F. Barker of Baltimore, specialist in internal medicine.

It is believed that much of past failure to deal successfully with criminals may be attributed to our neglect to give due consideration to the criminal himself and the causes—intrinsic as well as extrinsic—that have led him to commit criminal acts and to be in danger of embarking upon a criminal career.

Studies conducted by The National Committee for Mental Hygiene in various penal and correctional institutions throughout the United States indicate that a large proportion of the inmates of these institutions—and the same may be said of offenders passing through the courts—have from childhood behaved in a way at variance with average normal behavior, and that this abnormal behavior has repeatedly taken the form of criminal acts. Thus it is apparent that criminal careers, in a very large measure, have their origin in juvenile delinquency.

The prevention of juvenile delinquency is one of the most pressing duties of the present day. No problem of childhood is more serious than that of delinquency. The importance of centering all constructive work upon those forces that train children for a wholesome and socialized adult life cannot be overemphasized. The adult is what the child was. Whoever can control the mental, physical, and moral life of the child can thereby direct the child's future actions as an adult.

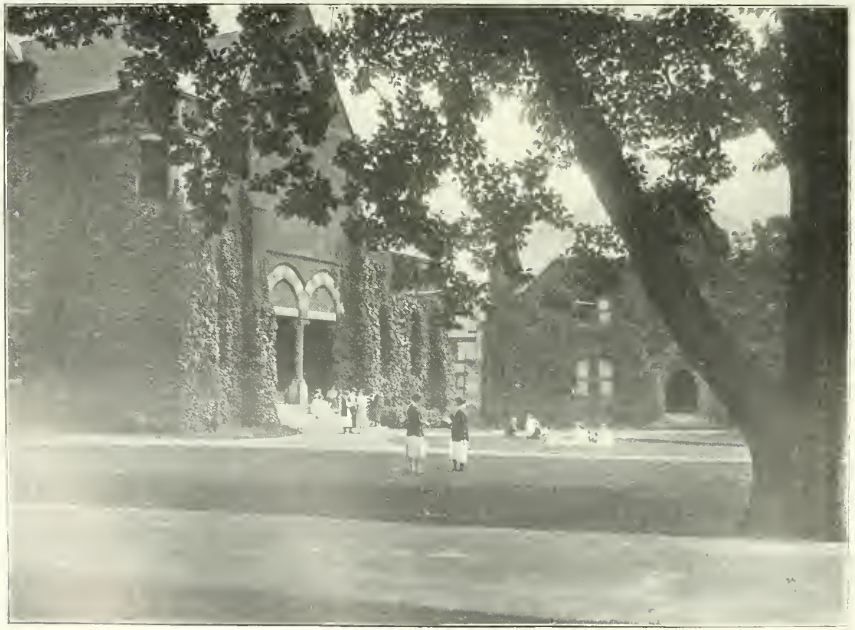
Valuable agencies have been created by society for aiding, developing, protecting, and caring for children, but the presence of large numbers of individuals who have not developed during their early years those qualities of mind and body which are the basis for normal adult life is an indication that less has been achieved than had been hoped. There is ample evidence that the causes of the failure of certain individuals can often be ascertained by the application of

scientific methods of inquiry. Through competent medical, psychological, and social diagnoses many of the factors that tend to produce delinquent careers can be discovered early and sound and constructive methods of treatment and prevention applied.

The significance of scientific studies in the field of juvenile delinquency is becoming increasingly apparent. Juvenile courts throughout the country are appealing for clinical facilities to aid them in dealing with that large army of maladjusted children whom we call delinquents. An extremely small number of the 2,391 juvenile courts in the United States are properly equipped for the scientific study of individual delinquents. Even where there is such equipment, the courts are often too poorly financed to give the full measure of service in the treatment and prevention of delinquency which the opportunities offered should enable them to do. Providing demonstration clinics to juvenile courts for limited periods will, it is believe, do much towards placing the work of such courts on a sound and scientific basis and will result, it is hoped, in the reduction of juvenile delinquency.

An Asset to Mental Hygiene Personnel

At a conference held in August, 1920, of those interested in the training of psychiatric social workers, one of the functions of such workers was defined as the making of social investigations contributing to medico-social research. As the first graduates of the first school for the training of psychiatric social workers—that established at Smith College in the summer of 1918—have been at work less than three years, it is not to be expected that they would have contributed much to medico-social research. What may be expected of them in this field, however, is shown by the type of thesis being prepared by the students at the Smith College school as a part of their work during the second year of their training. These theses are prepared not with publication in mind, but as an academic exercise in order that the students may have some experience in the gathering and organizing of original data. Among the subjects chosen by students for study during the past year are found the following: *A Study of 347 Cases of Manic-depressive Psychosis Discharged from the Boston State Hospital; A Study of 35 Ex-service Men Treated at the Boston State Hospital; A Social Study of the Dementia-Praecox Cases of Washtenaw County, Discharged from the Michigan State Psychopathic Hospital over a Period of 15 Years; The Results of Training in 25 Cases of Neurasthenia under the Federal Board for Vocational Rehabilitation; The Epileptic in Industry—a Study of the Industrial Histories of 28 Male Epileptics; Social Work with Traumatic*



College Hall, Smith College Training School for Social Work

Smith College Training School for Social Work, 1921

Neuroses; The Need for Mental Hygiene for Children Illustrated by the Experience of Medical Social Workers; The Employment of Neurocirculatory Asthenia Patients—a Study of 74 Cases.

Although not originally prepared for publication, five of the theses submitted in 1921 have seemed to warrant publication and have been accepted by MENTAL HYGIENE and other journals. One of these—*Inadequate Social Examinations in Psychopathic Clinics* by Miss Dorothy Q. Hale—was published in the October number of MENTAL HYGIENE; two others will be found in this number—*The Personal Psychiatric History* by Miss Lila Kline, and *Case Correspondence; a Method of Psychiatric Social Work* by Miss Elizabeth C. Hayes.

Miss Kline discusses the question, Who should take the personal psychiatric history? The question is raised not in reference to an ideally organized clinic, but in reference to a busy clinic, having the service of only one psychiatrist for three hours a day, although the experience of the psychiatrist and social worker in this clinic will have its significance for psychiatrists and social workers in all clinics. Miss Kline records her experience, leaving to the psychiatrists any conclusions that are to be drawn, although she expresses the judgment that while "the social worker cannot follow to the end any of the threads she may pick up, for these soon lead beyond her field and the range of her expertness, she can pick up and expose the threads so that they may at once be discernible to the psychiatrist who will follow them through".

Miss Hayes discusses a novel situation—a social worker faced with 2,000 patients scattered throughout the rural communities of Minnesota, North and South Dakota, and Montana. How are these patients to be reached, their morale maintained, intelligent support brought to their aid, hospital treatment obtained when necessary, and the recommendations of the physician carried out? It would seem an impossible task. One is inclined to smile at the thought of "treating" these patients (meaning, of course, social treatment) by correspondence. But one does not smile at the record of Miss Hayes's experience or at her conception of the full significance of the undertaking that was before her—"In handling a correspondence case it is necessary to keep in mind not only the immediate needs of the patient, but also the future attitude and adjustment of the patient's family and the point of view of the community to which it is hoped he will return. The policy is not to look upon any case as an isolated task—merely the problem of putting John Jones into a hospital—but as a means of introducing the average lay citizen to a better understanding of the problem of hygiene involved."

The success of the psychiatric social worker comes not alone from

the carefulness of her training in such schools as the Training School for Social Work at Smith College, the New York and Philadelphia Schools of Social Work, but in the quality of the young women chosen by these schools for training. Only those may be admitted to these courses who have had a collegiate education or its equivalent. The students at the Smith College school during the past summer were graduates of Vassar College, Bryn Mawr, Wellesley, Radcliffe, Mount Holyoke, Smith, Barnard, and state universities of the West and Middle West—in other words, young women with an educational background for the work they were to undertake. Given this preliminary background, eighteen months of carefully prepared and supervised specialized training, and a few years of practical experience in the clinic and field, this new type of worker will undoubtedly be one of the most valuable assets in mental-hygiene personnel. Already her value to the psychiatrist in bringing to him data that he cannot otherwise obtain and that are essential to him for the understanding of the case, and in helping, with her sympathetic understanding of the mental difficulties of the patient and her expert knowledge of community resources, in carrying out the recommendations of the physician, is well recognized. But a still further contribution may be expected from her as she becomes oriented in the field in the study of those problems, many of them of significance both to social work and to medicine, which lie between the two fields, but which are now neglected because workers are not available for their study.

Comparative Statistics of State Hospitals for Mental Diseases, 1920

The Bureau of Statistics of The National Committee for Mental Hygiene has published a statistical monograph with the above title dealing with the various forms of mental disease found among patients admitted to 77 state hospitals during 1920. Social facts relative to over 20,000 first admissions to these hospitals are presented, including data concerning citizenship, nativity, age, education, environment, economic condition, marital condition, and use of alcohol. Tables showing the number of patients, physicians, and employees, and expenditures for hospital maintenance are also included. Data relative to deaths and discharges from these hospitals are presented, including recovery, improvement, and death rates, and duration of hospital residence. Comparisons are made with the results of previous studies, whenever possible. Copies of the pamphlet may be secured without charge upon request.

Psychological Aspects of the Venereal Disease Problem

The United States Public Health Service has recently issued in pamphlet form the report on the proceedings and resolutions of the general conference committee of the All-America Conference on Venereal Diseases, held in Washington, D. C., December 6-11, 1920. The conference functioned largely through preliminary section discussion of questions submitted in advance by the members, and the reporting of recommendations from the general conference committee to the delegates for consideration and adoption of resolutions. There were the following twelve sections: (1) Medical research and laboratory questions; (2) Diagnosis and treatment of syphilis; (3 and 4) Gonorrhea in the male and female; (5) Public health and administrative questions; (6) Clinic and hospital questions; (7) Statistics; (8) Public information and education; (9) Law enforcement measures; (10) Protective social measures; (11) Psychological and psychiatric questions; (12) Social service.

Readers of Mental Hygiene will be especially interested in the report on Section 11, which is given here in full:

"Among the questions presented to the All-America Conference on Venereal Diseases, none aroused greater discussion than that dealing with continence (abstinence) in sexual relations for the unmarried. In this connection it must be borne in mind that the entire campaign carried on in the United States during the past few years has been based on the dictum that 'continence is compatible with health, and that it is the best preventive of venereal disease'. It was natural that this dictum should be of great interest to followers of the Freudian psychology; the statement was also critically regarded by physicians, represented largely by certain members of Section 2. The problem presented to the conference consisted mainly in harmonizing the views of those who regarded 'continence' from entirely different standpoints. On the one hand was the physiological and psychological view as to the effect of continence on health and physical and mental well-being, and on the other was the broad sociologic view which contrasted the alternative of continence with promiscuity and fornication.

"The original dictum cited above undoubtedly represents the point of view of the social-hygiene worker. The physiological view is presented in the more cautiously restricted statement offered by Section 2, as follows:

"*Resolved*, That the complexity of the question of the relation of continence to health is recognized. It is generally admitted that continence in the sense of total abstinence from sexual intercourse is not

a physiologic state in the sexually normal adult. On the other hand, the dangers and disadvantages to the individual and to the race which ensue upon the infringement of continence in the young unmarried man or woman are so serious that they outweigh the possible physiologic disadvantages of sexual abstinence.

"On the ground that dangers and disadvantages consequent upon infringement of continence were the same in older persons, the word 'young' was subsequently stricken out.

"Meanwhile, the psychological section had also dealt with the problem, their interest being chiefly in the alleged disastrous consequences of repression of the sex instinct. It was accordingly interesting to have Section 11 report on this subject as follows:

"*Resolved,* That although there is danger that a superficial and erroneous interpretation of the Freudian psychology in regard to the repression of the sex instinct may be detrimental to the successful development of the program for the control of the venereal diseases, a more thoroughgoing, complete, and scientific interpretation tends to aid such a program in that it places the emphasis upon the practical means for guiding the sex instinct into socially useful and constructive activities.

"With the discussion which the whole question of continence aroused, representatives of the various sections concerned subsequently coöperated and drafted the resolution which was finally adopted as expressing the views of the All-America Conference with respect to continence.

"This resolution is as follows:

"*Resolved,* That the complexity of the question of the relation of continence to the total well-being of the individual is recognized. Although it is generally admitted that, after maturity, continence in the sense of total abstinence from sexual intercourse is not a physiologic state, nevertheless the dangers and disadvantages to the individual and to the race which ensue upon the infringement of continence in the unmarried man or woman are so serious that they outweigh the possible disadvantages of sexual abstinence.

"Really a part of the continence problem is a question propounded to Section 11, as follows:

"Is there any danger that increasing success of programs of repression of prostitution will bring about psychological or psychiatric damage through sexual repression?

"To this the section returned the following reply:

"*Resolved,* That at the present time there is not sufficient evidence upon which to base a statement concerning any possible danger of

the repression of prostitution in producing psychological or psychiatrical injuries through sex repression.

"Taking up other psychological phases of the work in venereal-disease control, Section 8 called attention to the fact that any adequate program of sex education aiming at the development of sound normal attitudes toward sex and at the reduction of venereal diseases must be based upon principles empirically determined. For this reason the section—

"*Resolved,* That research be encouraged for securing data concerning the sex life of normal individuals.

"Of special interest to those guiding the educational and informational activities of the campaign against venereal diseases are the statements made by Section 11 with respect to the psychological stages in the development of sex.

"*Resolved,* That there are definite psychological stages in the development of sex, although exact lines of demarcation between them cannot be indicated. In general, these stages are:

1. The infantile period, including approximately the years from birth to four.
2. The pre-pubertal period, from the age of four to the appearance of puberty.
3. The adolescent period, from puberty to the age of approximately twenty-five, or until the time of marriage if it occurs earlier than this.
4. The marital period.
5. The senile period.

"*Resolved,* That any program of education in relation to sex should take account of these stages and should adapt informational matter, teaching, and training to the needs of each period. Furthermore,

"In the practical application of this, it should be recognized that what is characteristic or normal for one stage need not be characteristic or normal for another, and the aim should be to avoid arrest at any stage and to provide opportunities for the normal and natural progress of the individual to successive stages until complete development, involving normal sex relations in marriage, and satisfactions incident to normal, happy, family life (including the satisfaction of having and rearing children) be attained.

"*Resolved,* That any practical modifications of existing methods of sex education which should be made in view of our knowledge of the stages of sex development would involve practically a critique of the whole sex-education program and, therefore, cannot be considered by the conference."

Annual Meeting of the National Committee for Mental Hygiene

The twelfth annual meeting of The National Committee for Mental Hygiene was held at the Hotel Pennsylvania, New York City, November 10, 1921. Immediately following a luncheon for the members of the National Committee, short addresses were made by Dr. Walter B. James, President of The National Committee for Mental Hygiene; Hon. William I. Manning, Ex-governor of South Carolina; William A. Neilson, President of Smith College; Dr. C. Macfie Campbell, Director of the Boston Psychopathic Hospital; Dr. Thomas W. Salmon, Medical Director of The National Committee for Mental Hygiene; Mr. Clifford W. Beers, Secretary of the National Committee; and Mr. Cyrus P. Keen, who is directing the committee's financial campaign. The following officers were reëlected for the coming year: President, Dr. Walter B. James; Vice-presidents, Charles W. Eliot, Dr. Bernard Sachs, and Dr. William H. Welch; Treasurer, Otto T. Bannard; and Secretary, Clifford W. Beers. Members of the board of directors and of the National Committee whose terms expired in 1921 were also reëlected.

Importance of Neuropsychiatric Work in the Army

The following appreciation of the important work performed by the Neuropsychiatric Section of the United States Army during the war appears in *The Army Behind the Army*, by Major E. Alexander Powell:

"Though for a number of years prior to the war there had been a steadily increasing appreciation of the importance of neurology and psychiatry in the organization of a fighting machine, the theories which had been evolved along these lines were never put into practice, at least on a large scale, until America's entry into the great conflict, when there was organized the Neuropsychiatric Section of the Division of Internal Medicine. When the section was created, about fifty neuropsychiatric officers were commissioned; when the Armistice was signed, this number had risen to nearly 700. The chief function of the section was the exclusion from the army, by means of special tests, of men who, because of mental and nervous diseases, were considered unfit for military service. At first this section was treated with open derision or contemptuous tolerance by certain of the narrow-minded or the prejudiced—for the Medical Corps, like all other branches of the army, is not without its fogies who regard with suspicion anything that is new. The best proof of the success of its work, however, is the fact that it discovered the presence in the army, at home and overseas, of more than 72,000 men suffering from nervous

and mental disorders, every one of whom was a potential menace to our success as long as he remained in active service. Thanks to the simple, but highly effective tests which the psychiatrists devised, certain men were discovered to be moral perverts; the tests showed that others, if exposed to the strain of battle, probably would have suffered mental collapse, and that still others did not possess a sufficiently developed mentality to understand or to carry out orders. Imagine how grave a menace a single pervert might have proved to the morals of the men with whom he was associated in the intimacy of army life. Picture the danger to the success of a military operation of a single soldier who did not possess sufficient intelligence to understand the orders which were given him or the courage to carry them out. Such men were of far greater potential danger to the welfare of the army than were those suffering from tuberculosis. By means of the psychiatric tests given at the camps and cantonments, more than 1 per cent of all the men brought into the army by the draft were discovered to be mentally unfit and were at once rejected. On the other hand, many drafted men were found to possess exceptional mental qualifications and were thus marked out for assignments where their special aptitudes would prove of the greatest value, in many cases being recommended for the officers' training camps. This was the first war in which mental tests have been employed. Men with undeveloped minds, unstable nervous systems, or inadequate self-control are very bad risks for armies. They are unknown quantities and their behavior in moments of stress cannot be relied upon. Such men may cause disaster in action, they are liable to shell shock, and they are likely to swell the lists of pension claimants. But the psychological tests, though they did not entirely eliminate these dangers, certainly reduced them to a minimum, enabling line officers to equalize the mental strength of their commands by the reassignment or transfer of men to less exacting duties, or, in the case of those who were actually feebleminded, securing their discharge from the army and returning them to their homes."

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Howell Wright, Cleveland
*Robert M. Yerkes, Washington
Dr. Edwin G. Zabriskie, New York

Pearce Bailey
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MENTAL HYGIENE

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THE PLACE OF MENTAL HYGIENE IN THE PUBLIC-HEALTH MOVEMENT*

HAVEN EMERSON, M.D.
New York

IT is not because of any particular knowledge in the diagnosis or treatment of disordered mentality or the disturbances of conduct that I am permitted to share in this appeal for an intelligent understanding of the aims and necessities of our committee.

The part allotted to me is that of interpreter of the place of mental health, or lack of it, in the broad plan and service of preventive medicine, in which this country is now engaged through its official and volunteer health agencies. It has been quite inevitable, because of the peculiar genius of American effort, that the obvious, the immediate, the so-called practical needs of the sick should be first met and the theories and principles of prevention and action looking towards health promotion and protection be left until a new public opinion and a keener vision of relative values in medical services could be developed.

The appeal of the crippled child, of the consumptive, of the handicapped sufferer from a failing heart, is so direct and effective that little or no ingenuity or persistence is called for to obtain services to meet their respective needs, albeit nothing constructive or permanent is sometimes accomplished by our effort, beyond the sweet satisfaction of having done all that is humanly possible to relieve and protect, or to assist to better strength, and perhaps even to prolong the lives of the afflicted.

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May I be permitted to suggest that it takes a higher type of intelligence, a greater faith, a truer sense of perspective, to foresee the approach of disease and protect against it, to believe in the possibility of acquiring health and promote it, to see the enemies of health from afar, go out to meet them, outmaneuver them, outflank them, and down them by counter-attack, than to heal or tend existing disease?

This is the spirit of to-day, and nothing less than a determination to force the diseases already known to be preventable to retire, and, by enlarging our knowledge, to include the causes and means of control of those diseases as yet out of reach of preventive medicine, will satisfy the past generations of students of medicine and its allied sciences, whose trustees we are to-day.

It may be said without reservation that, incomplete as our knowledge is of much in medicine and of the true basis of the laws of health, we already have so much at hand which we fail to use that there is no excuse for idleness, and there need be no delay in action.

We have arrived at a point in the organization of our national effort for health where advances in the fields already preëmpted and liberally supported by public opinion and resources must wait for their entire success upon a fair beginning and progress in the most delicate and difficult and yet the most promising undertaking of all—the prevention of nervous disorders and mental defects.

We have seen the understanding of the public roused to successful action against that flail of the human race, tuberculosis, until we now reap rich rewards in a rapidly falling death rate from what has been until recently the cause of our greatest loss of life. In the last year, in the largest aggregation of human beings under one corporate government, in New York City, we saw a rate of loss from pulmonary tuberculosis of 89 per one hundred thousand of population, while but fifty years ago the rate was 408. A reduction of the death rate from tuberculosis of 51 per cent in the past twelve years among the six million people of New York City is an earnest of what can be done in other preventable diseases. Who would have dared to claim or promise any such extravagant

results when the first small beginnings of education in this subject were made, less than twenty-five years ago?

Shall we fear now to see visions and dream dreams of the goal approachable by our successors of the next generation in the field of mental hygiene?

Following hard upon the great anti-tuberculosis inspiration of a generation ago, lighted by Trudeau, Bowditch, Otis, and Biggs, and still a model for volunteer health organizations throughout the world, came the attack upon infant mortality, until last year we lost in New York City but one babe in fourteen in the first year of life, as compared with one in four, which was the experience of our large cities within the past forty years. And still we see possibilities and certain promises of a further reduction of infant deaths to less than half the present most creditable figure, and with this a saving of the mothers of the nation which will entitle us to rank first instead of fourteenth among civilized countries in the safety of the mother at childbirth.

Those devastators of the home, syphilis and gonorrhea, met now by clear thinking and clean speech, by honesty and self-control, begin to halt in their spread, and no one who saw education and high principle coupled with accurate scientific medical practice in the armed forces of our country can doubt that these diseases, too, will be recorded among the defeated ones within the next generation.

Even cancer has shown a tendency to recoil before those enemies of disease, the periodic medical examination, early and accurate diagnosis, and skilled surgical treatment, and yet education and technical resources have hardly begun to reach the mass of people capable of protection.

There enters the field now the intricate machinery of industrial medicine, alert to detect and avert the multitudinous calamities that attend our production of the needs and delights of modern life.

Hardly yet fully understood by physicians, but seized upon even in its incompleteness by teachers and housewives, we are already at grips with the disorders of nutrition, which have broken nations and decided the fates of armies, whether of men or of school children.

Latterly even the end results of other and more obviously

preventable diseases have come under careful medical and social study, and we see heart disease subject to an increasingly successful campaign of education and service, which promises well.

Against the habits of a nation, too, we have seen a gradual reaction follow the force of education until at present we find that most destructive of all habit-forming drugs, alcohol, forced out of commerce in this country, to the obvious and great benefit of all. Since social sanction has never approved of the use of narcotic drugs, we may promise ourselves an early success in controlling them.

It is true that no one of the specific health efforts we are engaged upon is complete in all its details, or has proved what are the simplest and most direct methods, or indeed what is to be the full measure of their success, and yet the plans of the leaders, the lessons of science, are such that we may truthfully say that we have marked out the ground of preventable diseases and allotted the responsibility for cultivation.

As the early enthusiasts have dug into their respective problems, they have come soberly to a common point of view—namely, that each effort in a particular field depends largely upon the state of cultivation and protection in adjacent ones. The workers in the prevention of tuberculosis, the protectors of babes and mothers, the guardians of social hygiene, agree that public health is a whole and cannot successfully be accomplished by a one-sided development dealing chiefly with one organ or function.

Each program of preventive medicine depends upon the thoroughness with which we discover all cases of the particular preventable disease in its earliest recognizable form. The tuberculosis services in New York have accomplished so much that, of the applicants for diagnosis at the public tuberculosis clinics, not less than 66 per cent were found to be nontuberculous in the year 1921. Similarly we are already finding that of those applying for special diagnosis in diseases of the heart at cardiac clinics, more than 25 per cent are not suffering from heart disease.

When can we say that at neurological clinics and psychiatric institutes more than half the people who apply have normal nervous systems and are free from disorders of conduct? Not

until then shall we know that we are beginning to control our problems.

From the point of view of cost, misery, and the numbers of our people involved, mental disease constitutes a larger problem than any of the others. In addition to the beds reserved for the feebleminded and for sanatorium care of the "nervous breakdown", there are as many beds for the insane in this country as there are hospital beds for all other diseases combined. And the significance of this is the greater when we see that the needs of medical, surgical, and tuberculosis patients are fairly met, while less than half of those suffering from mental and nervous disorders who should be cared for under medical direction apart from their homes are at present provided for throughout the country.

Whichever of the paths in the fields of health protection we tread, we cannot escape returning to the crossroad that binds them all together—the protection of the mind, the building of its strength, the guidance of its reactions, the unraveling of its difficulties, the destruction of its enemies.

The worst spreader of tuberculosis is the feebleminded open or active case. Irresponsibility is no more a personal liability alone than is communicable disease. The presence of the feebleminded or of those otherwise irresponsible and incompetent in a family or in a community constitutes the danger point in all the communicable and occupational diseases and drug addictions. How much of the burden of disease prevention can you put on a child of ten? How many adults are there in the United States with a ten-year-old mentality?

The control of all of the communicable diseases depends on early recognition of the conditions, their treatment, and, if necessary, the segregation of the patient. If we were free from the incubus of the feebleminded, our control of venereal diseases would be infinitely simplified, for whether among men or women, the spreaders of these diseases are chiefly those who are incapable of self-restraint or self-control, those who are inattentive to their physical health and fail to understand and follow the teachings upon which we depend to carry health and self-protection to the intelligent.

In the saving of maternal and infant lives, again, we come upon the irresponsible mothers of the illegitimate, where the

infant death rate is ten times that among children born in wedlock and reared with understanding of the simple rules of cleanliness, the necessity of constant protection of babyhood.

The accident list, the poison list of industrial workers, the turnover in shops, all represent problems of mental and social inadaptability of the wage earner, greater in extent, the lower the wages and the more precarious the occupation. Still we must attempt to deal with the physical conditions of workers alone for lack of guidance, education, and analysis of industrial human wastage by the psychiatrist. We see at least 75 per cent of poverty due to disease and more than half of this determined by mental incapacity or aggravated by disorders of conduct.

If the preventive service of the mental-hygiene movement had nothing else to its credit, we owe it the great dividends which have come from its teachings of the need and possibilities of occupational therapy. During convalescence and even in the midst of sickness, patients now work their way to health. The psychological asset of *busy-ness* in a hospital ward is now accepted.

The principles of the campaign for mental health are similar to those of other health problems. The technic of approach follows the methods used in diphtheria, in malaria, in infant mortality:

1. What is the extent and direction of the attack on the human mind?

2. Where is the enemy hitting?

3. What are his weapons?

4. Are the causes of his success primary attack on the mind or secondary effect of his by-products on intellect and emotions? Are they hereditary, infections, habits, customs, fears, superstitions, or religions?

We must have:

First, facilities for the examination of mental as well as bodily or physical fitness and performance. These are clinics, observation stations or wards, an alert and expectant body of trained physicians, and psychiatric social workers or nurses.

Second, records of the present distribution and incidence of mental disease and nervous disorders. Such records obviously must be continuous, to permit of comparison between com-

munities, and from year to year, and to give us hope of progress and a warning if our results are not improving.

Third, the survey or community diagnosis, which is needed for state, town, or county as it is for the individual patient. There is no essential difference in principle and objective between this and the surveys with which the public is familiar in tuberculosis, hookworm disease, blindness, or among cripples.

With survey facts—or, in other words, the diagnosis of a community—in hand, we can apply our education pointedly to the public. A public well informed on dangers and their causes spends freely for self-protection. For five dollars spent on diagnosis, the community will spend one hundred to a thousand on preventive treatment.

With research we arrive at new bases for social conduct and release ourselves for a new conception of the function of school, prison, court, and shop. With the new idea conceived by the student and proved by his research, we embark with confidence on demonstrations in mass to prove the result in practice.

To direct our efforts, we need a specialist in preventive as in curative medicine. This specialist shall be our consultant in mental hygiene, for school, prison, and shop, to whom educators and employers can come for advice. Our committees for mental hygiene serve the purpose of community consultants in the problems of mental health. These committees, both national and local, are the research students of the community, and execute studies on man in the mass, as the human discloses the manner of his mental defects only in contact and in conflict, in competition with his fellows.

The committee is also the center for the accumulation and distribution of exact information, to assemble, prove, and encourage results and warn new community efforts of failures due to old methods and unsound technic.

The specialist service for mental health will do in peace what the special consultant did in the American Expeditionary Forces—that is, save the mentally fit from the too common civilian practice of abusing, imprisoning, penalizing, and brutalizing the mentally feeble, the misfit, the temporarily disturbed. Specialist service means the same gentleness, judg-

ment, certainty, and success in saving minds as it does when applied to the saving of limbs, eyes, or lungs.

What we as a committee are searching for is some touchstone of humor, some gilded gift of oratory, some inspiration of the teacher which will give *us* a change of mind.

Why was it a disgrace twenty-five years ago to have consumption in the family?

Why did we hide cancer?

Why in our self-righteousness do we hide the syphilitic? Because we have had too little courage to seek and know the truth and prevent through knowledge rather than hide in ignorance.

So now we can see a time when the strange child, the strained mother, the confused and hounded workman will appeal to hospitals for relief from the twisted personality, the beaten brain, the incapable self-control as they now run to them for diabetes, appendicitis, or typhoid fever.

Why a broken mind or a half-developed character should be considered a disgrace, when broken cardiac compensation and lame joints are matters almost of family pride, is hard to see. Our education in these matters can't rise higher than its source. The medical student, until recently, has seen all varieties of flat feet and rarely had the army of deformed minds and characters passed before him. The psychiatric social workers of to-day are better educated in the causes and manifestations of the mentally abnormal than the rank and file of the medical profession.

This new conception of the social service of medicine through the practice of prevention in mental hygiene is proving a blessing to the physician of the body. It is reincarnating him as a physician of the personality as well.

We can't go forward on any public-health campaign without:

Public understanding.
Medical education and leadership.
Facilities for diagnosis and care.
Study, research, and information.

All health campaigns have gone through these phases. The principles are similar in all; the results in mental hygiene

promise more than others because of the quality of them. The essential spirit of health and happiness is mental and has a future as far beyond that of physical-disease control as the mind of man is the greater objective for which we build the healthy body.

As a student and practitioner of preventive medicine, I appeal to you, the public, to put into our hands as trustees the wherewithal to teach all that can be learned and applied for the discovery, protection, and repair of disordered minds. Until you feel this burden and this hope as you were convinced of the truth by the disciples of the anti-tuberculosis campaign of twenty years ago, your truly democratic generosity in the other fields of public health will not bring in its best or final returns.

You are asked now to reduce the salient of mental disease which dominates, as did the St. Mihiel salient, all other incidents in the grand attack.

Whatever the field of effort, investments in preventive medicine have brought in bonanza dividends far surpassing the prophecies of professors or health officers.

In our relations to our fellows, we owe them truth and escape from ignorance, faith in the lessons of science, the experience of physicians; or, as it has been better put by one who spoke of "Health as the first Wealth":

"A few great points steadily reappear, alike in the poverty of the obscurest farm and in the miscellany of metropolitan life, . . . These few are alone to be regarded; the escape from all false ties, courage to be what we are, and love of what is simple and beautiful, independence and cheerful relations, these are the essentials—these and the wish to serve—to add somewhat to the well-being of men."

The opportunity is yours.

The knowledge is ready.

The way is clear.

The facts call loudly for action.

THE PATIENT AND HIS ATTITUDE TOWARD HIS NEUROSIS

DOUGLAS A. THOM, M.D.

Chief of the Out-patient Department, Boston Psychopathic Hospital; Instructor in Psychiatry, Harvard Medical School; Advisory Consultant, United States Public Health Service

ALL individuals suffering from the so-called functional disorders of the nervous system naturally fall into one of two groups, according to whether the reaction toward the neurosis be an active or a passive one. The individual that belongs to the active group I conceive as seeking refuge in his neurosis. He is usually the inherently unstable individual, and it is because of this instability that the neurosis develops. The motive is usually obvious to the physician, although not to the patient, and also active—that is, it is present at the same time that the symptoms, whether objective or subjective, are being manifested. The symptoms are more frequently of a crude character, and the patient clings to them with great persistence. They not infrequently recur when the patient finds them to his advantage. The physician's emphatic index (attitude) toward these individuals is usually low, as the patient admits improvement with great reluctance. Suggestion is the treatment most frequently utilized in this particular group, and perhaps the two most common examples presented in the war neuroses were the anticipatory neurosis, found so frequently in the training camps, on the way overseas, and immediately upon arrival at the scene of conflict, and the compensation neurosis, which we are meeting frequently at the present time in dealing with the aftermath of the war.

To the second group, which I term as passive, belong those individuals who do not seek, but are overtaken by, their neurosis. Not infrequently these individuals appear to be normally stable. The motive or purpose of the neurotic symptoms is usually obscure and may be considered as inactive—that is, the stimulus itself is not in operation in conjunction with the symptoms, but only the emotion that was

attached to the primary experience. These individuals develop their neuroses in spite of their stability. Their reactions are more elaborate and are well exemplified in the amnesias and psychasthenias. They reach out blindly for help and are eager to note improvement; consequently the attitude of the physician (empathic index) is high, and there is an eagerness on his part to aid these individuals in making a proper adjustment toward life.

The following case is one that I conceive as belonging to the passive group—that is, it is the case of an inherently stable individual who is overtaken by his neurosis rather than seeking it.

Case 1: The patient's family and personal history are negative. He entered Base Hospital 117 about the fifteenth of September, 1918, and at that time had a complete amnesia for all events from the morning of April 11, 1918, up to and including October 25. The last event that he remembered prior to the onset of his amnesia was his landing in Liverpool and the first part of his march from the docks to the train. The intervening six months and fourteen days were a complete blank, and his first recollection after this amnesic period was of being arrested by one of the military police, whom he told that he was looking for his lieutenant, but to whom he was unable to give the name of his division or company or their geographical location. The patient was interviewed daily for eight days, an effort being made to restore the lost memory by means of association. Because all the events prior to his landing in England—that is, his early life, his occupational and school history, and military life—were intact, although he could not by associative methods go beyond his experiences on arriving at Liverpool, he was subjected to hypnosis and his entire memory restored in about two hours.

The points of interest that occurred during the amnesic period are as follows:

The patient landed in Liverpool April 11, 1918, and marched from the dock to the boat for Le Havre, arriving there April 15. He went into detail in telling of various moves from that date up to July 18, when his company was in position along the Marne River just to the right of Chateau-Thierry. He was in reserve at Chateau-Thierry, and was relieved

July 31 and sent to St. Mihiel, where he was held in a reserve position for the big drive. From that salient, his company was moved by auto-trucks to Souilly. Here he was transferred to the second battalion of the Fourth Infantry. On the second night his battalion moved up and relieved the first battalion. The next morning, when he got up, he found that he had been separated from his company. He states:

"I looked around all day, but was unable to locate the outfit. At night I returned to Montfaucon and slept. The following morning I returned to the train to go up with the 'chow detail', but it had already gone. I looked around until about one in the afternoon for my company, but without results. I then returned to the train, and Lieutenant Gamon, the officer in charge, told me where he thought my company was located. A detail was then going up to them with chocolate and other things, so I started out with them. We could not go through Montfaucon, as 'Fritz' was shelling it, so we took another road. Some shells began dropping on the road, so we lay down and waited for him to ease up. After about fifteen minutes, he stopped. There was only one of the men besides myself in sight, and we disagreed on which way the others went, so we separated to look for them, but I soon decided not to bother looking for them, but to go on with the company.

"The Germans had stopped shelling the town, so I went back and through. I left the road to cross the field to reach the woods where the company was located. As I crossed the field, I saw a man coming toward me. I did not recognize him as a friend, only as one of the company. *When he was twenty feet from me,* I heard a shell coming *and lay down. The shell struck him in the neck* and knocked his head off and buried itself in the ground about two *feet from me.* As I lay there on the ground waiting for the shell to explode, I could do nothing but look at his head. I was never so frightened in my life. I do not know whether *I was more frightened of the head* or *whether it was expecting the shell to explode.* Anyway, it did not explode. I tried to get up, but could not, for I was so weak I could not move. I remained there five or ten minutes, I suppose, but it seemed like several hours. After a

while I got up to go to the camp and a shell came over. I did not hear it coming. There was just a puff of smoke, then darkness. When I came to, I was about eight feet away from where I was first lying. I remember nothing else until the military police arrested me when I inquired for Lieutenant Gamon. I do not remember whether I went on to look for the company or whether I turned back. I believe it was the next day that I was picked up by the military police."

It was of interest to note that the patient, under hypnosis, showed little or no emotional reaction until he came to the event that was the exciting cause of his amnesia—that is, seeing the head of his comrade blown from his shoulders and lying in close proximity to a shell which he expected would explode. At this point the patient showed what was presumably the same emotional reaction that he had had during the actual event, exhibiting all the physical and mental manifestations of terror.

With reference to the amnesias, it is worth while pointing out that in these war situations, although the amnesia protected the individual from the memory of an intolerable situation, it did not incapacitate him from returning to the front. In fact, the amnesia in itself prevented an emotional reaction that would have incapacitated the patient for active service. This was clearly shown by the fact that the clearing up of the amnesia was frequently followed by an anxiety neurosis. We invariably found that it was a rather superior type of individual that developed amnesias during the war. We found that post-concussional confusions followed by amnesic periods, without any particular emotional disturbance, often cleared up suddenly and without any interference from outside, but the amnesias produced by psychic trauma would apparently persist indefinitely unless an effort was made to aid the individual to regain the lost memories. In a great majority of the cases, it was only the least automatic and the least organized forms of memory that were attacked, but occasionally we found that the habits and acquired skill of the individuals were forgotten in cases precipitated by psychic trauma.[1]

[1] I recall seeing two cases with Professor William McDougall, then at the Third Southern General Hospital, Oxford, where the reversions to infantile conditions were almost complete, even in talking, walking, eating, etc.

It is also of note that the toxic and concussional amnesias were never so absolute as the emotional group and they rarely cleared up as completely.

Case 2 (Active Type): This patient is an extremely well-developed and well-nourished young man, weighing two hundred pounds, height six feet, three inches. His family history is negative except for the father, who was alcoholic, and who is said to have had mental symptoms at the time of his death. The patient himself finished grammar school at fourteen, does not use either alcohol or drugs, makes friends easily, and has been able to adjust himself socially. Immediately following his typhoid injection at Camp Devens in October, 1917, the patient stated that he had had a queer fit in the night. These fits have continued every night excepting one up to the present time. They vary in number from three to thirty-five and are always of the same type: the patient suddenly turns over in bed and buries his head and face in the pillow until he loses his breath; then he lifts his head to get air and wakes up partly conscious. During part of this episode, he is unconscious; during the other part, semiconscious, but unable to speak. He remembers most events that occur.

He was awarded Federal Board training in January, 1920, and started in to learn the shoemaker's trade. He was allowed $80.00 a month by the government while in training. He remained at it only one week, when he gave it up and entered the hospital. After his discharge, the Red Cross found a position for him at light out-door work for four hours in the morning. This position he gave up after one day, saying that his sister had to get up too early in the morning to get his breakfast. The patient has been diagnosed as a psychoneurotic epileptic and treated for glandular insufficiency without any success whatsoever.

The physical examination was negative, excepting that the X-ray examination revealed what appeared to be some infringement of the pituitary by the clinoid processes.

The patient has been examined by a great many physicians. He takes a rather keen interest in the fact that his condition has not been diagnosed. He has considerable anxiety about his compensation, is very anxious to get a total permanent disability from the government, and lays more stress on this aspect of his case than he does on being cured. When asked

to come to the hospital for observation, he states that he will come in, but he wants it understood definitely that it is the last time that he is to enter a hospital. His general attitude is friendly and semi-coöperative. One feels that he is rather passive in his attitude toward getting better. On the other hand, he makes the necessary formal concessions for treatment.

We are here dealing with a condition that is psychogenic in origin and that fulfills to a very large extent the requirements of the neuroses of the active group. There is no evidence of any organic disturbance to account for the convulsive phenomena, neither are there any clinical manifestations to make us feel that it belongs to the group of idiopathic epilepsies. There is no evidence of any mental deterioration whatsoever, consciousness is never completely lost, and there is no reason to believe that other than the higher levels of the nervous system are affected. The man has been examined and reëxamined by various specialists and has received almost every drug in the pharmacopeia, although he admits that they have been of absolutely no benefit to him. One can conceive of the patient's primary neurosis as having been of the anticipatory type and the preservation and exaggeration of the symptoms of a compensatory nature.

It is rather frequently found that men who developed an anticipatory neurosis in the camps and on their way overseas are at the present time returning to the hospitals and clinics with a compensation neurosis.

There should ever be borne in mind the possibility—even the probability—that a very considerable proportion of the so-called war neuroses or mental conditions (not definitely psychotic) belong to what are commonly called the anxiety states rather than to the actual neuroses. These men are quite conscious of the pathogenic factors that are producing both their objective and their subjective symptoms. This fact has been strikingly demonstrated, both in this country and in England, by the tremendous increase in the number of men applying for treatment and compensation during the recent months of economic depression, and the complete cessation of symptoms following the alleviation of financial stress either by the securing of employment or the obtaining of compensation. Domestic difficulties, failure in vocational

training, disappointment regarding compensation, are commonly met with as exciting factors, producing a state of anxiety that is not out of relation to the stimuli producing it, and invariably the patient is quite cognizant of what his real difficulty is. These situations, of course, are very largely social and economic and must be treated as such.

Since the signing of the Armistice, it has been necessary to make some radical changes in our treatment of the functional nervous disorders that have been produced by mobilization, war activities, demobilization, and all the problems arising in this most critical period, which may be termed the transition of the soldier to civilian. At first thought, one would naturally presume that the results of treatment in these disorders would be decidedly satisfactory, more rapid, complete, and lasting. In fact, it was reported, shortly after the cessation of hostilities, that that event in itself would be sufficient to cure all the neurotic cases. But regrettable as it may be, the fact remains that we are still concerned with a problem that is not only of no small magnitude at present, but that is far from having reached its maximum, either in the number of cases to be treated or in the resistance that these cases are going to offer to treatment.

During the hostilities we had to face, in many instances, what appeared to be an insurmountable difficulty. We not only had to cure the man of his functional disability (deafness, mutism, paralysis, etc.) or to help him to assimilate and accept the reality of some terrifying experience, but we were also concerned with the problem of getting these men ready to return to the very environment that produced their original difficulties. In civil life it is considered wise and judicious, whenever feasible, to remove the patient from the environmental factors that produce his symptoms, but during the hostilities, the value of our work was measured by the number of men we were able to return to the field of battle. This difficulty is, to a large extent, removed in dealing with cases at the present time, yet, on the other hand, during hostilities we were dealing with the soldier and not with the prospective pensioner. We could appeal to his patriotism, to the traditions of his company, to his desire to get back to his comrades, and in many other ways stimulate his gregarious instinct to activity. The average soldier disliked

hospitals, with their monotonous routine. Treatment was firm and persistent. So on the whole there were many reasons that, when taken together, furnished an incentive that was a very important factor in the man's recovery. At present we are dealing with individuals over whom we have no legal or military control. A man can refuse or accept treatment as he wishes. No longer can we say to the soldier incapacitated by an hysterical paralysis: "You have been sent here for treatment. I have examined you and find that your condition is perfectly curable. I am going to cure you. It may take ten minutes or several hours. It depends upon how much you want to get well and how much you are willing to help me. When you leave the treatment room, you are going to be absolutely all right." This was the statement that we could make to our patients during the hostilities and feel sure that we would be able to keep our promise and get the desired results. It was a matter of being sure of your diagnosis and confident of your ability to remove the functional symptoms. The control and authority over the patient took the place, in a large measure, of the coöperation for which we have to beg at the present time. Very recently I made four definite engagements with an ex-soldier for an examination before he came to the office. I found he was drawing $90.00 a month for hysterical paralysis of the left arm and making weekly visits from a Vermont town to Boston for treatment. If I am not mistaken, he will be more difficult to cure than a similar case would have been three years ago behind the lines.

The problem with which we are confronted to-day, with reference to the neuropsychiatric cases, is very largely one of adjusting this active type of the neurotic group to their environment whenever possible. One realizes that in many instances this adjustment was far from perfect, even in pre-war days, and one should not hope for too much under present conditions. The great majority of these individuals returned to their homes after the war and for a longer or shorter period adjusted themselves to the old environment more or less efficiently, some poorly for only a few months, others very satisfactorily for a period of two or more years. Eventually we find that the present breakdown has been precipitated by some very definite environmental pathogenic factor. It may be an accident or an illness to the patient, possibly some sick-

ness in the family or financial loss, more likely unemployment or domestic difficulties. There are innumerable incidents of varying severity that may act as the exciting cause of a so-called nervous breakdown. It is during this period of social and economic maladjustment that the individual first makes contact with one of the numerous agencies interested in the ex-service man. He finally reaches the Veterans' Bureau, is put through the usual routine examination, and an effort is made to connect his disability with his war service. It may be frankly stated here that this is frequently no easy task. However, the fact is recognized that the man needs help, but more frequently than not the assistance that he needs is financial rather than medical, and the hospital is used as a means toward this end. The man's anxiety regarding his own condition, which has been built up by a process of rationalization, is substantiated by this step, yet the economic stress has been relieved; so, on the whole, it is accepted by the patient as a fairly satisfactory solution of his difficulties—that is, he reasons that if he were not ill, he would not have been sent to the hospital, and the fact that he is hospitalized entitles him to compensation, which dispels his anxiety over economic worries. In a recent report to the Surgeon General of the United States Public Health Service, by Dr. H. Douglas Singer and the writer,[1] the following statement was made:

"In essence, the neurosis is a 'way out' of some intolerable conflict or difficulty. The feelings of stress, apprehension, and worry that belong to the conflict are interpreted by the patient as evidences of disease or injury, the origin of which is referred back to some accident or illness—gassing, influenza, overwork, etc.—of the more or less recent past. The suffering is genuine and none the less real because the symptoms are ascribed to disease or injury."

And later:

"To place such a patient in a hospital is to confirm his belief in the existence of serious disease or damage. Furthermore, it very effectually brings a cessation of the responsibilities and needs for adjustment that brought about the

[1] See *The Care of Neuropsychiatric Disabilities Among Ex-service Men.* By Douglas A. Thom and H. Douglas Singer. MENTAL HYGIENE, Vol. 6, pp. 23-38, January, 1922.

disorder. It is often extremely difficult to discharge such patients; it is a much simpler problem to keep them out of a hospital. No man can be taught to carry a heavy burden by being relieved of the necessity for carrying anything at all. It is true that in some instances the burden may be more than the shoulders can bear. The shoulders must then be trained to bring them to their full strength. If it be found that the load is still too great, steps may be taken to diminish it, but it must not be removed entirely unless we desire to retire the individual from active participation in life."

After a most careful consideration of a plan that would seem feasible to rehabilitate this ever-increasing army of psychoneurotic individuals, that of well-organized out-patient clinics offered more advantages and fewer disadvantages than any other. It will be necessary, however, that compensation be utilized as a treatment measure in order that the patient and his family be provided for while he is under treatment. The organization of such a clinic will require an adequate staff of psychiatrists, psychiatric social workers, and a psychologist. In the larger cities, it will be found that the psychiatrists can be drawn from the men in practice who are willing to put in from one to three half days per week. To a very large extent social workers will have to be trained,[1] and arrangements for the same will have to be undertaken by the organization that assumes the responsibility of doing this rehabilitation work, whether it be the government itself, the Red Cross, or some other organization. The psychologist should be able to do much in aiding the prospective trainee in his task of selecting a vocation.

If the ex-soldier is rehabilitated in the environment in which he is to live, without the introduction of any motives that would tend to put a premium on the continuation of his symptoms, if he is treated by physicians who are trained and experienced in this particular branch of medicine, assisted in making his social adjustment by trained psychiatric social workers, and tested and measured to determine, in so far as possible, his capabilities and chances for success in industrial pursuits, one can then hope for a fair measure of success in

[1] Special training for psychiatric social work is now provided at the Smith College Training School for Social Work and the New York School of Social Work.

the tremendous task at hand. The problem of developing both a psychiatric personnel and a psychiatric social service must be met at once. The folly of appropriating millions for hospitals and organizing clinics without developing men to staff them is obvious, and steps are now being taken by the United States Public Health Service to have these needs fulfilled.

Closer coöperation between the departments that have to do with training, treatment, and compensation was brought to the attention of the Surgeon General in the same report to which I have previously referred,[2] from which I quote the following:

"There is no aspect of the problem that has to do with the rehabilitation of the ex-service man, except that of medical personnel, that is of such vital importance as the close coöperation between the departments that have to do with treatment, training, and compensation. Perhaps, to one who is not in actual contact with neuropsychiatric cases in a medical way, the logical sequence of events would be to restore the patient to the highest degree of efficiency by therapeutic measures before beginning to train him for some trade or profession in order to establish his economic independence. Under this order of procedure each department would work quite independently of the other, and the man would be shifted from one to the other whenever a cross section of the individual indicated the need for a change. However, as all of us who are dealing directly with the ex-service man know, this cross-section method has proved a definite failure. What is needed is a longitudinal section of the patient's life in order that we may consider his past experiences, his present needs, and his future possibilities. For example, if we are dealing with a mentally deficient individual whose war experiences have rendered him incapable of adjusting himself to his present environment and conditions, although his history prior to the war shows that he got along fairly well in the community, we cannot neglect his present needs, which may mean the actual necessities of life. These, of course, can be met only by compensation; and while future possibilities for this patient may or may not lie in training, certainly in such a case

[2] See note page 242.

training can be of advantage only if selected after a careful study of the mental equipment and temperamental fitness of the prospective trainee.

"The question of who is best fitted, by reason of experience, training, and opportunity, to decide upon the presence or absence of the particular qualities that account for success or failure in an individual is quite debatable, but, other things being equal—that is, intellect and opportunity for observation—it seems that the psychiatrist who has made a study of the particular case is best qualified to advise regarding the type of work for which the individual is best fitted by virtue of his physical and mental equipment, as well as by temperament and disposition.

"We very frequently find the man with a mental age of twelve to fourteen years struggling along in some trade or profession that is obviously not within his grasp. The more ambitious and persevering the man, the greater the conflict between his ambition and his achievements, and sooner or later we find him seeking refuge in a neurosis. The same is true when an individual fitted for manual work begins to take up accounting; when the lad who craves outdoor life finds himself shut up in a factory; when the man who is quick and impulsive is forced to do work that requires caution and deliberation; or when the individual who works well under supervision suddenly is thrown into a position that demands responsibility. All of these individual questions must be considered when dealing with problems of vocational guidance.

"We do not intend to convey the idea that the neuropsychiatrist should take the place of an expert trained in the problems of vocational guidance, but that he should advise with this expert or furnish him with all the data at hand pertaining to the prospective trainee's mental equipment and temperamental fitness for general types of work. It seems to us that in this way many of the glaring mistakes that have occurred in the past will be obviated. It may be well to repeat what has already been said elsewhere—that a large percentage of the relapses among the neuropsychiatric cases in training are directly due to their being shunted off into some trade or profession for which they are unsuited."

The necessity for a broad and comprehensive plan that will include every available means at the disposal of the government is quite apparent. Physicians with tact and skill, social workers armed with proper training and experience, psychologists with judgment and foresight, and a smooth and efficient working administrative organization are essential to the rehabilitation of the ex-soldier incapacitated by mental illness.

In an article published nearly three years ago on this very problem of rehabilitation,[1] I endeavored to point out some of the difficulties that would be encountered in our effort to liquidate our debt to the disabled ex-soldier. I stated that there is an inertia both mental and physical, often associated with depression. Some of these men are imbittered. They feel that they have a grievance against the country for which they have sacrificed so much. They seem to be viewing the world through colored glasses; the period that begins with the soldier's recovery and continues through his convalescence, his discharge, his return home, his efforts at seeking employment—in short, that transition from the soldier back to the civilian—is perhaps the most trying in his career. It is fraught with many disappointments. The glamour and glory of being a warrior are no longer present, the comradeship of his fellow-soldiers is gone, all the excitement has passed away; it seems for a moment that life holds nothing worth while. Its emptiness becomes oppressive. The soldier feels himself forgotten. The perils of this period of transition cannot be overestimated. Any plan that involves the independence and happiness, not only of these soldiers, but also of their families, cannot be taken too seriously. The efficiency with which the problem of restoration is conducted through these next two or three years will be reflected in the generations to come. Later, I stated that our chief danger is going to be in taking the path of least resistance, refusing to settle the problem to-day because it is difficult, forgetting that in a few months it will be hopeless. If the public allows the disabled soldiers to drift back to civil life, satisfied with some temporary misfit of a job that can only serve the purpose of a livelihood for the person, we shall be confronted in a short

[1] *Transition from Soldier to Civilian.* By Douglas A. Thom. *The Medical Quarterly, The Canadian Journal of Rehabilitation*, Vol. 1, pp. 342-49, October, 1919.

time with thousands of pauperized soldiers. The result is inevitable. It seems worth while to sound this warning again.

Let us not forget that most of these lads gave the best of what they had. There is a limit to the amount of physical stress and mental strain that every individual is capable of withstanding, just as there is a limit to the intellectual heights that each of us may reach. The neurosis is the individual's effort to seek a happy solution of his problem, crude, cumbersome, and misdirected, but none the less an effort. We must keep in mind that although the motive for the neurosis may be perfectly obvious to the physician, it is not so to the patient; that is why it is a neurosis. Frequently we use methods that are ill adapted to the particular case; as some one has said: "The pick and shovel are used when a rake could do the work." Yet this is not the greatest danger. More frequently, we find that the terms "faker", "malingerer", and "gold-bricker" are used by those who, failing in their therapeutic efforts, seek consolation in this method of rationalization. We should bear in mind, as I have stated elsewhere, that there is no nation in such a favorable position as we are to do justice to the problem under discussion. Our problem, large as it is, does not approach in magnitude that of other nations. We are dealing with individuals who to a large extent belong to the big class of occupational workers. They are just in the bloom of life. Forty years would probably not measure the path that these men have still to follow, and we are to decide to a large extent what these years shall hold forth for the ex-soldier.

PSYCHIATRY, PSYCHOLOGY, PSYCHOLOGISTS, PSYCHIATRISTS*

WILLIAM HEALY, M.D.
Judge Baker Foundation, Boston

THE principal aim of the science of mental life can hardly be other than a right understanding of mental activities—in order that human beings may experience the best possible mental growth that brings better accomplishment and more happiness. What does the science amount to, or of what concern is our attitude towards it, unless results are produced, distant or immediate, for our human kind?

My specific text is a certain alignment that has taken place—psychiatrists over against psychologists, or at least psychiatry over against psychology. But there is more to the matter than these positions taken; considerations are at once implicated that have to do with the very upbuilding of the science itself.

We must see perspectives; to begin with, how nascent we are in this task of trying to understand the inner life of the human animal. Psychopathology has only lately first won some apparently basic facts, applied psychology is now in the throes of coming into being; the study of mental mechanisms as bearing upon practical issues is altogether recent, the age-level arrangements of the few mental tests that we use began only a dozen years ago or so. On the other hand, there are many pathological conditions of mind poorly defined and resting upon unknown bases, and there are yet to be recognized and studied for norms plenty of "intelligences" or capacities that we need to know about in order to grasp the significances of many reactions in life.

Compare the growth of psychology with that of the other sciences whose subject material surely cannot be as complicated, the mind being the most complex organism in our universe. Here we see physics, for instance, just for practical

* Read at the meeting of the American Psychological Association, Princeton, December, 1921.

ends examining and dealing with materials through conceptions and formulæ and methods of approach that are immeasurably finer spun and better thought out than any that exist as yet in our field. Shall we not venture to expect such developments with us or with those who follow us?

Our achievement so far in understanding the life of the mind is, of course, built upon contributions from mental pathology as much as from normal psychology. Great enlightenment has come from those in the medical profession who have been students of deviations from the normal, much in the same way that investigations of bodily disease have been essential to the development of our knowledge of physiology. But in the field of mental pathology we find one portion—namely, that of mental defect—which for generations has been under control of the medical profession, lately made particularly fruitful by the psychologist. Indeed the recent work of psychology with defectives has already proved most valuable for the growth of better understandings of many facts concerning mental life. Mental defect is evidently not amenable to medical therapy, but concerning social therapy, practical adjustment, it is rich ground for the educational psychologist.

The situation to-day presents the psychologist and the psychiatrist both attempting to gain deeper knowledge of the constitution of mental life—and, fortunately, both without confining themselves to special theories. Difficulties are arising because of attempts to interpret mental life or behavior in particular cases without taking into account, not only the viewpoint of the other side, but also part of the factual material obtainable as it bears on the whole problem in hand. Are illustrations necessary? The naïve accounts of mentality in terms only of "intelligence quotients" on the part of so-called clinical psychologists (a term which I considerably dislike) can be paralleled by even recent reports by psychiatrists of cases and whole series of cases where mental capacities (intelligence?) are quite obviously most important factors, and yet no notice whatever is taken of the possibilities of objective determination of such prime elements of the mental life.

The psychiatrist comes to what sometimes is almost purely a psychological job with a very curious lack of training, not

only in an up-to-date psychological technique, but, what is worse, often without a knowledge or appreciation of just where psychology stands to-day. In the medical curriculum one spends much time on organic neurology, but it must be confessed that knowledge of even the finer anatomy of the brain or of its pathology leads but a very short distance toward knowledge of the mind. Why, even concerning mental diseases, in psychiatry itself, the cry is that medical schools are offering very little instruction. In fact, what is there in the whole of an ordinary medical education that in any way justifies the physician in qualifying as a psychologist? If medical men have attained position even in the world of medico-psychology, it is because they have trained themselves otherwise than in formal medical education or in the medical schools.

In dealing with adults, whose educational and life adjustments are for the most part made, the descriptive data of mental disease has usually been considered enough of psychology for the psychiatrist, but with the pushing back of genetic investigations to the really formative periods of life and with the advent of the psychiatrist among children, working very rightfully for mental hygiene, a formidable body of very different sorts of psychological fact is, or should be, met. Whatever one's school of modern psychiatry, it seems to be acknowledged that it is the affairs of adjustment of the individual's mental life that are fundamental for study. Adjustment, certainly at an early age, involves volition, emotion, habit, associations, the various elements of intelligence, memory, judgment, apperceptions, etc., and even imagery type and special learning capacities. These afford important data for evaluation in addition even to the wonderfully valuable matters pertaining to the mental mechanisms which have been so stressed recently in psychogenetics. There are vastly important matters concerned with function, yes, but there are underlying these the facts of structure, of potential.

Is it necessary to say that many such data belonging to individual or differential psychology and educational psychology are quite generally overlooked in psychiatric practice, or that these are important for an understanding adjustment? (Shall one cite, for instance, the immensely interesting problem of the relation of school adjustment, so important for mental

hygiene, to special mental aptitudes?) Or need one call attention to the burden of work for the psychiatrist if proper study is to be undertaken of the data of differential and educational psychology?

We have the very obvious weakness of the position of the psychologist who attempts to pass judgment upon problem individuals in that he has had no good training whatever in knowing the effect of abnormal processes, physical and frankly mental, upon the mental constitution and function. Even invading the school system where he would seem peculiarly to belong for the purpose of diagnosis of individual problems, he is in considerable danger because of possibilities of overlooking abnormal personality trends and even mild psychoses, to say nothing of other dynamic features of mental life which are not brought out by tests and other observed reactions. And when it comes to the handing out of opinion about young individuals by teachers who have had a few weeks' of training in testing, who are not even "clinical psychologists" (we know whereof we speak), the situation is bad indeed.

Attempt to cover the two fields is nearly always unfortunate. Some psychiatrists are using some few psychometric tests without even a few weeks of training, we might say without anything like the education in technique that is demanded for bio-chemical tests. And as for covering an adequate range of tests and the skilled interpretation of the results of tests, altogether harder and most necessary, the importance of this has not struck in at all. I am not aware that there is any such extensive similar undertaking on the part of practicing psychologists to cover the ground of psychiatry. Protests have well arisen against commitment, through courts and otherwise, by psychologists because they are not qualified to give a medical and psychiatric examination, but if one may be allowed to speak from long and varied experience, protests can much more justly be lodged against physicians and even psychiatrists who offer opinions and sign commitments concerning purely psychological matters equally without proper psychological examination.

As time goes on, I find myself more and more inclined to question the extraordinary values placed on classifying the individual nowadays by the results of a limited number of

tests—an exceedingly limited number, considering the immense complexity of mental powers and processes. It seems as if this sort of study of mentality was aiming at something nearly as simple as a statement of body weight or of a plus or minus reaction of the blood. Does not a numerical report of intelligence seem absurd if taken alone, without analysis and statement of special powers and incapacities? I wonder how many of us would feel that we might be fairly known with regard to our mental capacities by our "rating" on any one of the sets of tests. We find accepting this ready method not only practically minded professional psychologists, teachers with an interest in mental diagnosis, and people taught psychometry as office assistants of physicians are taught to do clinical tests, but we see psychiatrists also handing out opinions that concern mental structure and function in just these ludicrously simple terms. There is a great temptation to leave the paths of psychology, even of differential psychology, which are hard to follow; there is evident willingness to disregard many factors (such as the effect of attitude of mind and specialized powers and functionings) which really make the interpretation of tests difficult—and all for a scheme of mentality evaluation that is a flimsy foundation for the details of a superstructure of practical adjustments.[1]

Of course, the question must frequently arise, who is the proper or properly trained person to deal with given problem individuals, especially with children, with whom most of the work in practical psychology is done and to which sphere medico-psychology particularly desires to extend itself. In out-and-out cases of mental disease, with all the possibilities that we hope may develop in medical treatment, the rôle of the psychologist is subservient. But such cases are very rare in childhood. With mental defect—as witness the work in special school classes and even the only really therapeutic work in institutions for the feebleminded—the psychological diagnostician and psychologically trained educator have the

[1] One might wonder whether the statistical aspects of psychological work which have been recently so much to the front and which of course are of tremendous value for establishing sound objective standards for individuals and groups are not responsible for the feeling that there is some great value in placing a number, an "I. Q.", after a person's name.

right to take a high place. Progressive physicians, as heads of institutions, have had to school themselves in these matters.

Out in the field it is generally found much easier to get a good physical report as diagnostic aid than it is to get well done the prolonged study of mentality that is necessary, for all except low-grade defectives, in order to institute good therapeutic and ameliorative effort. That in these matters it should be suggested that the physician ought to be the only one to deal authoritatively with the individual or that adjustments should be carried out under direction of the psychiatrist alone is strange indeed. Is this idea not based merely on precedent? We see no other reason for it. Ruling out physical troubles and mental disease, the psychiatrist has no special contribution to make, and in many cases where there are factors of physical irregularities and minor psychotic conditions the possible special adjustments are so primarily educational and psychological that at least there should be thorough coöperation and equal responsibility, rather than subserviency of either psychologist or psychiatrist.

It may be that psychologists adequately trained to grasp the possibilities of these fields of applied psychology are still so rare that they have been able to command as yet insufficient respect in the minds of psychiatrists. But with the rapid growth nowadays in numbers and in intensity of training, there is much more chance of the equality that is fair to the sciences, to the workers, and to the problem under consideration. Further development of the science of psychology itself will tend to ennoble the work of the psychological practitioner.

And when it comes to what is called psychoanalysis—meaning by this no special cult—it is an open question whether psychologists handling certain problems not requiring treatment as diseases may not do just as well in practice as psychiatrists. At least they are likely to take more into account certain fundamentals of the personal equipment, differences in talents, habit formation, and reaction types, which are vastly important, side by side with the fact of repressions, conflicts, complexes, inhibitions, and so on. The strange phenomenon of all sorts of people entering this enticing field of meddling with other people's minds—journalists and various kinds of laymen as well as quite unequipped physicians and psychol-

ogists—calls for the condemnation that only something like an adequate supply of competent psychiatrists and psychologists can make strong enough.

Many more considerations might be focused upon the cardinal points of our discussion—namely, the growth of a strong practical psychological science and the relations of psychologists and psychiatrists. But the upshot of it all seems to be as follows:

Psychiatrists should realize that:

1. The facts concerning abilities, general or special, belong to quite a different province from the facts concerning mental balance or mental disease, and one does not invalidate the other. There is a distinction, thus, between capacity or structure and dynamics or function.

2. The determination of capacities, which has a technique all its own, requiring special training, and the proper use of the results of psychological tests, means much more than simply following a set of directions. It demands interpretations based upon sound knowledge of general and particularly of educational psychology.

3. There is much experimentation going on in the field of psychology and there is a constantly accumulating body of literature and of new tests, many of which are of value. To keep up with this is no small undertaking.

4. There are many problems of poorly adjusted individuals which are much more truly psychological than psychiatric—they involve not only diagnoses, but also adjustments to school and vocational life, both of which are distinctly beyond the ordinary working considerations of the psychiatrist.

5. There is no reason why the well-trained psychologist is not capable of giving valuable testimony concerning mentally defective persons, even when commitment is in question, if diagnoses of possible physical and mental disease are accounted for. Defectives are not mentally diseased in the ordinary sense. On the other hand, the psychiatrist in many quarters is not even familiar with the critical methods of determining special mental defects or the best terminology in use.

Psychologists should realize that:

1. Problems of mental capacities cannot properly be answered without diagnosis of possible physical and mental disease.

2. All problems of the psychoses and neuroses require special training for recognition, study, and treatment. The psychologist having little knowledge of them, coöperation with the psychiatrist is indispensable for him; otherwise he is liable to do harm.

3. The psychologist who is not interested in or who is unfamiliar with the dynamic phases of mental life—special interests, effects of experiences, repressions, "driving forces" —is totally unequipped to study problems of maladjustment.

4. At least until we have better means of objective measurement for emotions and personality traits, these must be evaluated in descriptive terms and this up to the present has been better done by psychiatrists than by psychologists.

5. Many psychologists in practice are unfamiliar with the best even in their own field, of much that has been developed by experimental methods in the field of applied psychology.

Both psychiatrists and psychologists should realize that:

1. There is vastly more to be learned both in applied normal and abnormal psychology.

2. Each must learn to appreciate the other's field. There is no rational opposition or conflict; the work of each is complementary to the other.

3. Adequate training in both fields is impracticable for nearly all and hence there should be good teamwork for the sake of answering the specific problems of the individual and for advancement of the science. When it comes to case studies, both psychiatrist and psychologist should sit in conference.

4. As it stands now, psychiatrists are more accustomed to the use of descriptive terms. Psychologists are at present finding themselves able to develop more objective methods. But neither invalidates the work of the other. The effort on the part of each should be toward the establishment of objective standards which are the only criteria of a well-established science.

5. The wonderfully promising trend of to-day is toward betterment of human lives through constructive and even reconstructive work with children. Perhaps more than other therapies, there is possible educational therapy by wise adjustments during school age. For this is demanded a consideration of intricacies which call into play the best that normal, educational, and abnormal psychology have to give.

I am not sure that I am making friends in either camp by these didactics, but I have found myself really appalled by the psychometrist who passes out far-reaching judgments upon the individual from the standpoint of a few mental tests inadequately interpreted, by the psychologist who offers diagnosis, prognosis, and definite advice based upon a cursory psychological examination without any deep consideration of the physical, personality, or even social features of the case. And I am equally appalled by the psychiatrist or neurologist who renders a diagnosis of mental capacities, perhaps announcing mental defect, or who gives advice concerning specific educational and social needs, without consultation involving report on any sufficient range of mental tests, or even without any careful study of mental capacities at all.

It is with thought for sound progress in the several fields of the science of mind rather than to interrupt recent contentions that one asks this fair consideration of several phases of the work of to-day in psychiatry and applied psychology. Warmth of feeling not infrequently leads to fine exertion in competitive effort. We may benefit by many thus incited possible developments in our knowledge of mental life.

But on the whole it will probably be through the rivalries and finer criticisms of good-fellowship, particularly not through complacencies and feelings of finality in one's own point of view, that the best progress will be made. It is in thought of such pulling together that one may be allowed a beatific vision of vast benefits accruing through better understandings and realizations of man's mental potentials.

THE NEXT STEP IN THE MENTAL-HYGIENE MOVEMENT

CHARLES P. EMERSON, M.D.
Dean, University of Indiana School of Medicine, Indianapolis

THE mental-hygiene movement has made such splendid progress during the short period of the past fifteen years that it is wise now to plan carefully for the future. There is so much that might be done that there is great danger of dissipating effort along too many channels instead of concentrating it at a few stragetic points.

It would be easy to give a general answer to the question: What are the immediate objectives in mental hygiene, the most promising fields in which to work, and the best methods to be employed? But it is not easy to choose the specific problems best worth while just now. As one interested, not in neuropsychiatry, but in the broader field of internal medicine—which includes practically all the problems of neuropsychiatry while they are still very indefinite and yet are more easily handled than they will be later when they clearly belong to the specialists—we would answer as follows: Just as physical hygiene, to speak accurately, is not an independent subject, but rather the reflex of general medicine—in much the same sense that the answer to a mathematical problem owes its value to the accuracy with which the various steps of the problem have been taken—so mental hygiene is hygiene only if it represents the logical conclusions of pathological psychology and neuropsychiatry. You cannot, short-circuiting these, arrive directly at mental hygiene. Of course we are speaking now of preventive medicine with regard to mental disease and defectiveness. This it is that also separates the wheat from the chaff of that great mass of confused ideas gained from experience, tradition, or superstition that have formed our rules of living. To give a concrete example of the above idea, and one better understood by laymen, we would say that the immediate object of the societies for mental hygiene should be now, as in the past, the continued educa-

tion of the public until the "average citizen" sees clearly that mental disease is disease and that the patient is sick and needs a hospital and expert care and not a jail. Accomplish this, and the problems of mental hygiene will soon be answered. Fads ruled in physical hygiene until the "average citizen" was convinced that tuberculosis was spread by spitting, typhoid fever by water containing sewerage, yellow fever by mosquitoes, etc. After that, the problem of handling these diseases became much easier. Just so, fads and fancies, freak systems of education, Binet tests in the hands of enthusiastic psychologists, and unorthodox religions, will dominate the so-called mental-hygiene field until mental diseases and defects are better understood by the public; and this means a campaign of education by expert neuropsychiatrists, the formation of more societies, more public meetings, and more popular literature, but all under expert supervision.

One of the chief reasons why we should begin and continue our campaign with the public is that the difficulties to be overcome are, both as regards their origin and their final solution, social in character. This will be evident if we remember that for the present unfortunate attitude of the "average citizen" toward mental defectives the average citizens themselves have been to blame. The extensive hospitalization of mental patients far antedates that of medical and surgical cases. In this hospitalization the safety of the public alone was considered, certainly not the welfare of the patients. So awful was their plight in state institutions, once these institutions had fallen into the hands of politicians, that stringent laws were soon enacted to prevent the unnecessary incarceration in these asylums of any "free citizen".[1] One result of this is that the term "insanity" is a legal and a social rather than a medical term, one that our medical students are taught to avoid, since

[1] See *The Don Quixote of Psychiatry*, by Victor Robinson. New York: Historico-Medical Press, 1919. 339 p. Except in possibly a few of the less progressive states, no such conditions now exist. Politics is still a blighting influence in some state-hospital systems; in the more progressive states, the influence of the politician is gone. The tendency throughout the country is to remove the state hospitals from political control and to place them in the hands of medical men specially trained in the diagnosis and treatment of nervous and mental disease. With the development of hospitals along these lines, the laws restricting admission are being repealed and laws encouraging and permitting voluntary and temporary-care admission enacted.

the courts alone determine insanity, not the doctors. The term insanity really implies only that the mental condition of the person affected is such that it would be considered no injustice to deprive him of liberty or the control of his property. We doctors are not allowed to decide this; we merely convince a suitable court official and he, if he is convinced, commits the patient. If, later, doubt concerning the insanity of a committed person should arise, the question will be decided by a jury of twelve laymen. The inevitable result has been that commitment is a late resort for conditions believed to be incurable, and that the public considers the stigma of commitment of necessity a great social injury.

During the past twenty years the progress made in neuropsychiatry is astonishing. We all agree that mental disease is disease; that the mental patient is a sick man, who deserves as much consideration and as little disgrace as the man ill with typhoid fever. He needs a hospital, not a jail; he needs real treatment for his illness by experts, trained nurses, and attendants; he needs hospital care, not merely bars, bed, and bad food. He should be grouped with other patients according to the actual treatment he is to receive and not, as at present, with the "quiet" or "excited", the "clean" or the "dirty".

But how can we "get this across" to the public and through them to the state legislatures? At first thought, one will say that the responsibility should rest with the general practitioners of medicine. They, in close touch with the families of their patients, should be able to see the first evidences of troubles that for years may not be conspicuous to others; they can advise, prevent, meet troubles while advice is of value and prevention and treatment are possible. The general practitioner could perhaps have done this during the past generation, had he had the information that we now have, but he never has had it and the chances are that he never will. These subjects were not taught in medical schools twenty years ago and the chances are that in the future they will be taught less than now during the undergraduate years.

Neuropsychiatry is an advanced subject suitable only for a postgraduate course, and postgraduate students do not intend to become general practitioners. The real trouble is that

the earlier the case, the more difficult is diagnosis and the greater need is there for an expert. Better that the specialist refer such cases back to general practitioners with the problem outlined for them rather than vice versa. To-day, thanks in part to the societies of mental hygiene, many laymen go direct to the consultant whom they—not the general practitioners—choose, and we imagine that more and more will do this.

Let us continue this discussion concerning the general practitioners further. Could societies of mental hygiene, did they so desire, bring such pressure to bear on medical faculties that more neuropsychiatry would be taught during the undergraduate years? The modern reformer evidently believes that legislation could make even an intemperate pedagogy good. Doubtless more and better neuropsychiatry could be taught than is now, but the chances are that the one result of the reforms in medical education now pending will be to decrease rather than to increase the amount of neuropsychiatry now prescribed for undergraduate medical students. This is inevitable. Our medical faculties must require less in order to teach better. The problem of the undergraduate medical course is to lay a solid scientific foundation for the student's future professional career, and four years are none too long in which to train the student well in general medicine and surgery; and only he who is well trained in general medicine has any business to begin the study of neuropsychiatry. The result is that not only neuropsychiatry, but also other specialties necessary for an efficient knowledge of neuropsychiatry—pediatrics, ophthalmology, etc.—will be pushed out of the four-year course and into the postgraduate years. But, insist our reformers, add a required fifth year to the medical course. Yes, we expect to do this some day, but such a year must in large degree be a year of elected specialization, and the chances are that no more will elect nervous and mental diseases than now follow this subject in postgraduate schools.

But, some might still say, why discuss neuropsychiatry? Our interest is in mental hygiene; at least more mental hygiene might be taught the medical students? It is of interest in this connection that there has long been in progress a discussion as to why our medical schools teach during

the undergraduate years so little physical hygiene, a much older subject. The argument used in the one case will fit the other, and is, briefly, this: While the well-established truths of hygiene can and should be understood and practiced, not only by doctors, but by every intelligent citizen—who, although quite ignorant of the evidence that supports these truths, nevertheless can see reason in them and will accept them on faith as empirical knowledge—yet hygiene as a conquering science can be developed only by those who approach it by mastering the sciences of which it is the logical conclusion. Hygiene is the final and perfect fruit of the medical tree. The ability to teach others accurately how to keep well is possible only to the man who first understands well those diseases which endanger his well-being. There is no short cut to hygiene. Show us an apple that has been produced independent of an apple tree and we will grant the possibility of a true mental hygiene that does not spring from a clear understanding of neuropsychiatry; and this in its turn is the fruit of general medicine. Of course this body of truth, once developed, may be accepted as a finished product that bears no sign of its origin. Even the members of religious sects that are hostile to the medical profession accept and practice very accurately the tenets of advanced hygiene—practically all of which came directly or indirectly from medical-school laboratories—evidently believing that since no mention is made in them of illness or disease, they may hold to the one and despise that which produced it.

But what are we driving at? Merely this: that the mental-hygiene movement should be directed only by expert neuropsychiatrists, and that the public must be educated to accept and to support these leaders. We are not afraid of the amateur who knows that his ideas are borrowed, but we are of the man with a little knowledge who poses as an expert. The serious question in the field of mental hygiene to-day is, Who are the experts? It is to the great credit of The National Committee for Mental Hygiene that they have chosen as their executive officers only neuropsychiatrists of splendid training and national reputation. Must not state societies for mental hygiene do the same? It is the state society that influences the state legislature.

We emphasize this, for we feel that a tragedy is pending. There are a large number of psychologists, of doctors (also masters and mere bachelors) of philosophy who, armed with the Binet test and a brief, superficial experience in hospitals and dispensaries for mental cases, are posing as specialists in mental hygiene; there are too many social workers who are specializing in this field who feel that they have "a mission"; there are too many faddists, quacks, and psychopaths who are literally wallowing in these ideas. All of these workers could prove very useful; all may be necessary; but only if they consent to work under the expert direction of the one whose ideas of mental hygiene rest on expert knowledge of neuropsychiatry and this on general medicine. There are no short cuts into leadership in this field, certainly not through psychology, sociology, or nursing.

What, then, is the next task of the mental-hygiene societies? It is, we believe, the careful selection and adequate support of experts connected with each state society. Adequate support means that these experts must have control of adequately supported psychopathic dispensaries, hospitals, or both, where as many as possible of the early or suspected mental cases may be studied and treated, and that the society must use its influence to secure the acceptance of these experts as authorities by the public and as directors of their work by the less well trained.

NERVOUSNESS: ITS CAUSE AND PREVENTION

AUSTEN FOX RIGGS, M.D.
Stockbridge, Massachusetts

MUCH confusion has arisen in the language that deals with mental phenomena, especially during the last few years, so that before plunging into the subject of nervousness, I wish to define very briefly in just what sense I use certain much used and abused terms.

In the first place, the term psychology is often given, at least by implication, many mysterious and confusing meanings. This is not surprising when one realizes that it is only during the last century that psychology has gradually emerged from the status of a psuedo-science, a sort of unimportant tail of metaphysics, into recognition for itself. In our generation its terminology has been mutilated and the pieces appropriated by dozens of semi-religious, semi-philosophical cults, false healing systems, and well meant, but misguided floods of pseudo-scientific popular books, dealing with everything that has for the public the least element of mystery in it, from the action of the digestive organs to spiritism.

Briefly, psychology is only a sort of inclusive physiology. It deals with human behavior, with the response of man, the wise animal, *homo sapiens,* to his environment. Just as physiology deals with the reactions of his separate organs and groups of organs to their extrinsic and intrinsic environment, so psychology deals with the response to environment of man as a whole. The object of human psychology is plainly, then, to interpret human behavior and finally to predict what that behavior will be under given circumstances.

Mental hygiene may be considered a subdivision of psychology, one of its medical branches. To be more definite, it is the psychological branch of preventive medicine. It concerns itself with the ways and means, the rules and regulations, necessary to normal behavior—that is, to normal response of the individual to his surroundings.

Finally, to avoid confusion, let us assume a definite meaning for *environment*. Let this term include everything not included under the term individual. In short, it is the world in which the individual "lives, moves, and has his being". It has its physical as well as its mental aspects. To both of these aspects it is the individual's problem to adjust himself. The physical elements of environment, such as food, clothing, and factors tending to physical violence and disease, are the business of physiology, of physiological medicine, of preventive and physical hygiene, and are not, therefore, germane to our present subject. The mental elements of the environment, on the other hand, which are essentially the social elements, are very much our present concern. These are the elements that are definitely and specifically the business of mental hygiene.

The social aspects are *par excellence* those to which man as a whole reacts in terms of behavior. There are, in the first place, things or situations that seem to threaten or protect the integrity of his life as a whole, and that are to him markedly agreeable or disagreeable. The outstandingly important situations are, of course, made up of other people to whose lives he has to adapt himself, and who, on the other hand, are adapting themselves to him. To insure adequate and skillful adjustment to these primarily social aspects of his surroundings, to prevent the accidents and illnesses peculiar to maladjustment—in short, to help the individual to initiate and to maintain habits of normal and effective response—is the primary object of this psychological branch of preventive medicine called mental hygiene.

Among the most frequent and the most commonly misunderstood results of a poor adjustment of man to his environment is the condition that we call "nervousness". Simply through applying a little of the knowledge already formulated by mental hygiene, a great many, probably all, cases of "nervous breakdown" could be avoided. To cure this condition when once it is established is the concern of a special branch of medicine. This obviously requires a knowledge of the nature of the disorder on the part of the physician. But it is not quite so obvious that a similar, though far less extensive, knowledge on the part of the prospective patient himself is

required to prevent, and *will* prevent, such a condition from developing. This knowledge fortunately need not be as full or as detailed as that required of the physician to cure; and, equally fortunately, it is true that such sufficient knowledge exists, and furthermore that it is available to any one of moderate education and intelligence. It only needs adoption by the thinking public, especially by parents, to cut down the incidence of nervousness to an enormous degree.

Mental hygiene is as yet very young, but as it grows older, it will grow wiser, it will offer more and more of its knowledge in usable form, and there will be less and less necessity for nervousness, fewer and fewer nervous breakdowns. Even now it offers enough to enable us to say that nervous breakdowns are not only curable, but are distinctly *preventable* disorders.

Now as to nervousness itself, as I have already intimated, this condition is the result of imperfect response on the part of the victim to the social aspects of his surroundings. I now wish to add most emphatically that "nervousness" is not a *disease,* but a *disorder.* It is not a disease of the nerves or brain or of any other part of the body. It is not "auto-intoxication". It is not "weakness of the nerves", or exhaustion, or fatigue, nor is it a perquisite of the idle rich. It is none of these things. In other words, I want to make it quite clear that it is purely and simply the result of maladjustment on the part of an otherwise perfectly sound, essentially normal person, and that therefore it is both curable and *avoidable.*

The mentally and physically unfit obviously cannot respond normally to their surroundings. They are *inadequate.* They constitute an entirely different problem. In them we often find an exhibition of wonderful courage, resulting often in the most glorious victories—the triumphs of the handicapped. Appealing as these cases are, we must leave them to another chapter of the subject, for just now we are dealing only with nervousness, and this is not inadequacy, but inefficiency. Our problem is the most hopeful problem of all, for we have the splendid prospect of complete cure, of absolute prevention of future failures of adjustment, of the maintenance of complete usefulness, of the saving of a vast amount of misery and suf-

fering, not to speak of thousands of dollars' worth of wasted energy and talent; for we are dealing with good, sound, undamaged material, handicapped by mismanagement only.

Nervousness is largely a personal problem, a question of personal reactions, and the answer can best be summarized in the phrase, "Know thyself." There is no mystical implication in this phrase as I use it. It means simply, definitely, and specifically that self-knowledge psychologically and ethically is the best assurance against nervous breakdowns. Some general impersonal understanding of normal psychology—in short, of human behavior as a whole—is manifestly the necessary foundation for this essential self-knowledge, and it is likewise the basis of mental hygiene.

Types of Response

Human psychology, as I have already said, resolves itself into a study of the responses of man *as a whole* to his environment. Roughly speaking, there are three types or kinds of response into which human behavior can be divided—reflex, instinctive, and acquired.

In the first place, each one of us is born with a psycho-physical apparatus which responds in its various parts reflexly to changes in its surroundings. A reflex has to do with the adjustment of a part of the body to some stimulus. For instance, let an irritating substance be applied to the mucous membrane of the nose. It responds reflexly, and the response is a sneeze. Various organs and groups of organs in our bodies respond similarly by change of function to the varying stimuli that are brought in contact with them. The stomach responds to the presence of food, and varies its function according to the nature of the food present. The pupil of the eye contracts to the stimulus of bright light and dilates in the dark. The respiratory and circulatory organs respond reflexly to the quality of the air we breathe, on the one hand, and the varying demands of the body for oxygen on the other.

But the human apparatus has other inherent dynamic tendencies, which are, to all intents and purposes, highly compounded reflexes involving not parts of the body, but the whole individual. When these are set in motion by the appro-

priate stimuli, the whole individual responds as a unit, and this we call instinctive action. Instinctive action is always accompanied by its appropriate emotion. Indeed an emotion is an intrinsic and inseparable part of its instinct. Conversely, one may say that an instinct depends absolutely on its emotion for its dynamic force. An instinct is no more and no less than an inborn tendency to react in a certain predetermined manner to certain conditions or stimuli. For example, an infant, if hungry, reacts in a certain predetermined, characteristic way in response to food; also, if the desire for food is frustrated, we can safely predict that he will react instinctively in another perfectly specific and definite manner. One instinctive reaction being frustrated, another, usually that of pugnacity, takes its place; much energy is mobilized and expressed, and in the expression we recognize that instinct's own appropriate emotion—in this case, rage.

As another example, consider what happens extrinsically and intrinsically when the cat sees her hereditary enemy, the dog. The response is immediate, specific, and effectual. She presents a picture of mobilized energy. The mobilization is furthermore absolutely appropriate for the purpose—namely, defense or escape. The extrinsic signs of this status are stiffened muscles, rigid legs, arched back, erect tail, and bristling hair. Intrinsically, there are other signs. The heart is beating rapidly, sending a greatly increased amount of blood to the muscles and to all other organs of locomotion. That blood furthermore carries to the motor apparatus increased quantities of readily oxidizable material due to the action of the internal, so-called ductless glands. The digestive organs, not being needed for the emergency, are in a state of temporary paralysis—put temporarily out of business, so to speak. All of these internal as well as external changes are part and parcel of the emotion of fear. The cat undoubtedly feels the emotion as an irresistible impulse that with remarkable swiftness impels her to escape. Presumably without thought, as mechanically as a gun is discharged by a pull on the trigger, the cat at the sight of the dog runs. Should she meet an unclimbable fence, the instinct of escape will immediately be replaced by the instinct of pugnacity and quite as inevitably will she turn with rage to fight her pursuer.

Thus, if one studies the behavior of animals, one sees instinctive action in its pure, unaltered form, especially in wild animals. For instance, a loud noise to most animals is the adequate stimulus to set in motion the instinct of escape, and the emotion fear, which is an essential part of this instinct, literally lends wings to the animal's flight.

The third variety of action in human behavior is that of acquired modes of response. These are largely modifications of instinctive reactions. These modifications are brought about by training the intelligence and will, which are as conspicuous by their absence among animals as they are by their presence in man.

For instance, we *learn*—that is, we acquire—the habit of responding in certain conventional ways to the presence of tempting viands. If acting instinctively and without acquired control, we should respond to the smell and sight of food by simply devouring it, and, if interfered with, we should as simply fly into a rage and fight. Furthermore, we learn to modify our instinctive actions by intelligent control, not only for the purpose of substituting some opposite action more appropriate to the occasion—such as doing the right and intelligent thing even though fear, let us say, bids us run away—but we train the very instincts themselves to greater perfection of action. We may become skillful fighters if need arise, as well as self-forgetful and reasonably self-sacrificing citizens.

There are two important elements that profoundly affect human behavior and that vary greatly in strength in any given individual. The first of these is *temperament*. This is a qualifying characteristic. Briefly described, it is a tendency to be oversensitive or undersensitive to such items in the environment as usually produce in any one markedly painful or markedly pleasurable sensations and emotions. Oversensitiveness to one's own emotions and sensations naturally leads to overvaluation of their significance and importance, which of course directly affects behavior. If a sensation or an emotion is valued as a very disagreeable one, and almost intolerable in itself, one's thoughts and efforts are naturally bent on getting rid of it or modifying it. If, for instance, one is oversensi-

tive to the disagreeableness of fear and fear itself is therefore overvalued, it is treated as an item to be avoided at all costs, and life is accordingly modified, consciously or unconsciously.

The other element, which is difficult to define, and which I shall not even attempt to describe, but which must be reckoned with as of the greatest importance in human behavior, is that which we call *spiritual*. It expresses itself more or less concretely in ideals. These ideals are frequently in conflict with our instinctive demands, and this conflict, through its interference with the realization of ideals through action, constitutes the fundamental problem of human conduct.

On the one hand, animals, without the power of choice, presumably without spiritual impulses, are impelled in any situation by whatever happens to be the instinct or instincts aroused by the then present environmental stimuli. They do not preside over the conflict of instincts, nor, presumably, is there any conflict between the strongest instinctive impulse and some ideal demand. They are frankly and simply subject to their instincts and their behavior is proportionately simple and direct. A cat, when she sees her enemy, the dog, feels the emotion of fear, which puts all of her machinery of flight into action. Unless the expression of this instinct is blocked by an insuperable obstacle, her flight continues until the emotional force is exhausted. If the flight is blocked, the instinct of escape is immediately replaced by the newly aroused instinct of pugnacity, and she quite as inevitably fights. But all of this presumably without choice or without reason.

On the other hand, the human being presides over the conflict of his own instincts, felt by him as a conflict of emotions. He presides over this conflict with intelligence and with a consciousness of the power and necessity of choice. This would be a comparatively simple process if it consisted merely of choosing which instinct was to have expression; or if it were only a matter of choosing which was the most expedient manner of obeying that instinct—whether hiding, running, or "playing possum" would satisfy the situation. The strongest instinct would always win, and it would be merely a matter of adding intelligent planning to instinctive action to make that action more effective. However, fortunately or unfor-

tunately, the other great element that I mentioned comes in with its demands—namely, the spiritual. The ideal of service and self-sacrifice may demand of a man whose instincts would drive him simply and quickly away from danger that he shall stand fast and neither hide nor "play possum", but sacrifice himself without recompense of any sort, except the spiritual, even to complete self-destruction. It is when intelligence and will are used to realize an ideal through an action which is contrary to instinctive demands that animal behavior rises to the dignity of human conduct. To keep instinctive forces under the intelligent control of the will, in order to realize through these very forces our ideals—that is to live a civilized life, a happy life, and furthermore a healthy life.

Environmental Difficulties

The inherent instinctive outfit of man, it is safe to assume, has been very little altered since history began. He is very much the same animal as he has always been. He has the same reflexes, the same instincts, the same primary emotions, and probably very much the same intelligence as he has always had. In short, during the history of civilization his original outfit during his lifetime, all of these fundamental inherent elements, have presumably been changed but little. But his environment has changed enormously and with great rapidity. The mode of life in a single generation has often changed from that of primitive man fighting for survival in a frontier wilderness to the highly civilized and complex existence of city life.

The physical elements of man's environment, it is true, have changed greatly during the progress of history, but these changes are not of a kind to tax his adaptation severely. To be free from the hardships of hunger and cold and exhaustion, to be warm, well-fed, and well housed and no longer subject to exhausting physical strains, requires a very slight and a very simple sort of adaptation. But the social complexity, the multiplication of tempting opportunities that such physical changes imply, these do tax his power of intelligent adaptation. The social factors have undergone an enormous change, from primitive simplicity to their present complexity

and rapidity, and it is this rather than the physical change that makes adaptation difficult. Physical comfort and safety, it would seem, have been won through multiplying mental and moral risks.

Ease of communication by rapid transit, telephone, telegraph, labor-saving devices, all sorts of time and space annihilators, are the things that, in my opinion, are largely responsible for our difficulties of adjustment. These labor- and time-saving devices are highly beneficial in themselves—as labor-saving devices. They broaden one's horizon, multiply one's opportunities, and are capable of saving much energy and of conserving leisure, if wisely used. Only when they are used as leisure killers, only when we allow them to tempt us into trying to do three things at once, making two blades of grass grow where only one grew before, only when we use them to accomplish the impossible, to crowd a life's work into a few years, are they harmful—but then they become the very instruments of the devil.

Think of the difference between the mental processes of the modern business man and those of his old-fashioned prototype of the nineteenth century. In that golden and primitive past, whole days would be consumed in the completion of an only moderately important business transaction. A good bit of friendly intercourse and social entertainment, much that was gracious in manner and speech, form to the point of elaboration, were considered assets in those courtly olden days. Such time-consuming processes were part and parcel of the old-time merchant's business activity. There probably was no such thing as the chronically tired business man, for everything he did was comfortably packed about and upholstered with little pleasant, healthful things that took time.

Compare the old-fashioned picture with what we are familiar with in the modern business man's office. He arrives by rapid transit, elevated, automobile, or what-not, or even by airplane, at a huge, noisy structure which he enters in company with a crowded, hurrying stream of other preoccupied speed maniacs. Having taken not more than perhaps a hundred steps since breakfast, he is shot upward at a terrific rate, probably in an express elevator, and is hastily ejected at the

twentieth story within a half-dozen steps of his office. There, if his organization is "up-to-date", he will find things already started, perhaps going full tilt. His mail is already opened, even sorted for him. He does not waste the fraction of a minute between shedding his hat and coat and beginning to dictate his replies and give his orders. Even while dictating, he will hold not one, but several, conversations of importance on the telephone; and before finishing these, it is more than likely that he will be starting a third activity of some sort, such as interviewing a client. In short, he does probably in an hour of what to him is an ordinary business day as much as the old-fashioned chap did in a week. Does he leave the office any earlier because of this wonderful speed? Does he gain leisure? No indeed; he stays just as long or longer, but he makes more money. It hardly needs scientific argument to prove which type of life means longevity, let alone contentment, happiness, and health.

I do not mean to imply that the modern citizen is less intelligent or is less wise than his forefathers. On the contrary, I believe that the problem is far more hopeful, for I am sure that he is just as wise, just as intelligent, and has all the wisdom of his forefathers' accumulated experience to draw on, if only he would. But I think it is clear without argument that be he wiser or less wise, his modern environment calls for the exercise of greater wisdom, for greater adaptability, than were necessary a century or more ago. Obviously there is greater speed, greater emotional strain, a greater tendency to let quantity of effort spoil the quality of life. In short, the greater wealth of opportunity is fraught with the danger of a greatly increased temptation to unwisdom.

Difficulties of the Sensitive

Yet it is true that normal, evenly balanced people—that is, the great majority of people—can and do most successfully adapt themselves to these entirely extraordinary factors of modern life. But to the inherently oversensitive individuals, this present environment of ours offers increasingly tempting dangers and pitfalls. For the hypersensitive, more emotional person tends to *over*-react, especially to things that

normally produce markedly painful or markedly pleasurable emotions in most of us, and especially to avoid such things as produce markedly painful reactions. Thus the behavior of a certain minority of people tends to be impulsive, emotional, instinctive. It tends, therefore, to be unplanned, hurried, incomplete, and superficial and clashes with the strident, speedful world of the present. Instead of guiding themselves wisely among the environmental difficulties, they succumb to its temptations and dangers. These oversensitive and overemotional people tend to act according to how they feel and then to apply judgment and will only when it is practically too late.

Wishes and fears tend to distort thoughts. We all tend to believe rather what we wish were true than what is true. But when this characteristic is exaggerated, perhaps chiefly through lack of training, it obviously makes for poor adjustment to the world as it is, and maladjustment leads directly to malcontent. Malcontent frequently expresses itself in the pseudo-philosophies and cults that describe the world not as it is, but as they wish it were.

The nihilist and anarchist, the parlor Bolshevik, the cubist and the free-love doctrinaire, are examples of essentially maladjusted and discontented people. They imagine a world that in each case shall contain the element that they most crave personally, and a world, also, that shall be free from the obstacles to achievement and obstructions to self-expression which they have found most difficult and most annoying—a world of commerce without money, capital, or labor, without management or competition; a social world without laws or customs; a world, in short, without those restrictions and necessities to which they have found adjustment difficult, and which they wrongly blame for their own mediocrity or lack of success; a world where their weaknesses shall be assets, where their supposed strengths shall make them leaders without competition or effort.

These people are essentially neurasthenic—that is, they are nervous. If they could be given self-knowledge, it would cure all of them, and they would then find contentment and happiness in accepting their world as it is as the basic starting

point for good work, as the raw material out of which to forge success.

As an example of how ignorance of the essentials of a problem in personal adjustment leads to a poor solution, the war neurosis is most instructive. (This condition, by the way, is often misnamed "shell shock", for the shock of a nearby exploding shell is only very rarely associated with the beginning of the disorder.) A man, usually somewhat hypersensitive to his own emotions, often with an essentially timid personality, finds himself in a position of extreme danger, or if not actually in the position of danger, on his way toward it. His ideals of honor, of service, and of loyalty push him onward toward the goal from which his instinct of self-preservation, through the emotion of fear, is doing its best to hold him back. Through misconception he has learned to consider fear as synonymous with cowardice. His own essential self-esteem excludes cowardice from his idea of self. Indeed, as a matter of fact, he *knows* he is not a coward. Therefore, it is impossible for him, in the face of this prejudice, to recognize or acknowledge the presence of fear. Fear, however, is what every normal man must feel when in danger, and furthermore this emotion, like all emotions, is not just a mental state, but is actually also a bodily state, a state of mobilization of bodily forces, a state of preparation for immediate flight, and it has very marked and noticeable physical signs. Among these are a rapid and often irregular heart, tremor of the muscles, a dry mouth, and disturbances of the stomach and intestines. One man cannot help being disturbed by these physical disorders, which, largely because they are neither understood nor recognized, become exaggerated. They finally constitute a bodily condition which becomes the innocent focus of his fear. Fear of breaking down physically he can recognize and can acknowledge without prejudice to his character. He can with spiritual safety be afraid that his physical condition will interfere with his carrying out his ideal of service. In short, he can recognize a fear of failure from bodily causes over which he has no control, whereas, in his ignorance, he cannot acknowledge that he is afraid of being killed or horribly maimed. The emotional state becomes ever more tense, its physical symptoms more

marked, until they dominate the picture, and he is actually disabled by disordered or paralyzed bodily function. The deadlock of the conflict between his ideal of service and his instinct of escape is incidentally broken by the condition produced by the emotion, for that condition makes it physically impossible for him to go on, and much against his will he is *ordered* to the rear—a case of "shell shock".

Had he known that fear is the one occasion and the only occasion for courage, and that it is *not* synonymous with cowardice; had he had sufficient knowledge of his own psychology to recognize fear as part of the normal and universal reaction of any human being to danger and courage as the spirit in which one does things in the face of fear, his problem would have been a very simple one—namely, whether or not he could do his duty, even in spite of being filled with fear. He might have had, probably would have had, a short, but decisive moral struggle, but he would have brought his will to bear upon a clean-cut, soluble problem, and he would undoubtedly have gone through successfully.

The same is exactly true of the more complicated neuroses of ordinary civil life. Knowledge of the factors of the problem of adjustment is the first step and the absolutely essential step toward a successful solution, and as in the war neuroses, given the requisite knowledge, we can be quite sure of finding the strong desire, the will to get well, ready to apply itself to the problem as soon as the latter can be made clear and definite.

Recognition of Elements in Childhood

To prevent the occurrence of "nervousness" is, then, obviously the problem involved in the prevention of maladjustment. Whether tender-mindedness is acquired by early contagion from nervous elders or by lack of training, as in the case of a spoiled child, or is partly inherited, may be left as an academic question. However this and other elements that make for nervousness may arise, it is the business of the mental hygienist to recognize these elements as early as may be, so that, being recognized, they may be trained from being liabilities to being assets. The time for this recognition and

training is in childhood, for it is then that the seed of nervousness is sown.

I believe that the following are the most important of these elements that tend toward nervousness, on the one hand, and are particularly amenable to training on the other.

The temperamental tendency toward oversensitiveness to the markedly painful or markedly pleasant emotions and sensations is perhaps the most common and fundamental element which, if unrecognized and uncorrected, makes for later nervous breakdowns. This element is recognizable even in the early months of life. Whether it be inherited in part or in whole or merely acquired by circumstances is not important to our present discussion. That it is recognizable in very young children is most important, for this fact presents one of the earliest and most hopeful opportunities for training.

All of us, especially when we are children, are sensitive to our own emotions to a greater or less extent and are especially appreciative of the pleasurable emotions. But a certain proportion of children are *over*sensitive to emotions, particularly to painful emotions. They give physical evidence of this extra sensibility by over-reacting physically to correction, disapproval, and punishment. They show the over-reaction most often not only in being over-prone to weep, but also in disturbances of digestion and circulation. They may lose their appetites, their bowels may become disturbed, or they may even react emotionally to painful situations by an attack of vomiting.

On the side of circulation, they are the children who blush and blanch easily. They may also show an overexcitability of their kidneys and sweat glands. In short, they perspire too easily under excitement, cry too easily, and likewise their overactive kidneys, under the same circumstances, may lead to one of the most embarrassing accidents of childhood. Too often this latter unavoidable accident meets with severe and unjust punishment.

On the mental side, they show a greater dependence than normal on praise and approval and especially an exaggerated sensitiveness to disapproval. They show the latter by avoiding conflict with authority as much as possible, either by ex-

aggeratedly good behavior or by deception and lying. Their repugnance to the disagreeable—whether it have to do with the touch of a disagreeable surface or substance or a disagreeable taste or with being too easily and too markedly influenced to avoidance of such things as may arouse in them a painful emotion, such as fear—is evident and conspicuous.

These signs of the oversensitive temperament, as I say, are easily recognized in early childhood and call for definite training. Usually they are noticed, but rarely are they understood and often quite the wrong training is applied. Punishments are made too drastic, or the parents sedulously plan to avoid all discipline wherever possible and so to arrange the child's environment as to avoid the production of fear or any other disagreeable reaction. Both of these extremes are apt to lead to the same result—namely, an increase in the sensitiveness, a further accentuation of the very handicap that they had intended to remove.

On the other hand, the training should have in view the distinct object of molding the sensitiveness itself into a useful force. The first steps of this training are to give the child a true valuation of tolerance of the disagreeable, and to help him to a realization of the naturalness and normality of the emotion of, let us say, fear, which only needs a little courage to combat it. At the same time, an appreciation of the necessity and importance of adapting himself to the needs of his playfellows can be aroused through stimulating his interest in team play, which makes a good basis for normal courage. For instance, instead of telling a child that he is silly to be afraid to go into the dark room, that there is nothing there to hurt him, that he *ought* not to be afraid, or that he is a baby to be afraid, he should be told that *of course* he is afraid, that lots of other children are afraid of the dark, even though there is nothing to be afraid of. He should be shown that being afraid is one of those disagreeable things that we can get over by not thinking too much of it, and that at all events he is of course going into the dark room to get the game or book he wants, because he wants it. It can thus be shown him by the actual demonstration of going into the dark room and getting the desired game in spite of fear, in the first place, how harm-

less that little fear of his really is, and, in the second, how comparatively easy and fully worth while it was to get the game—a little victory, but lots of fun when won. Every effort should be made, in other words, to accentuate the importance and desirability, the satisfaction and fun, in free objective action *in spite* of rather than *because* of sensitiveness. Every effort should be made to make the interest in doing things and the results of doing things always stronger and more enticing than the abnormal and introspective interests that the child may have in his own emotional reactions.

Such training, for instance, is quite capable of turning timidity into habitual courage, sympathetic pain into the professional understanding and practical, purposive sympathy of the genuine physician or nurse. Such training can transmute sensitiveness to color or sensitiveness to sound into intelligent appreciation and thus make of it the professional understanding of the successful artist or musician. One can turn this sensitiveness by such training into useful, objective appreciation of the physical and social environment, including the needs of others. Thus a liability can be turned into an asset.

The second element making for nervousness, which is, as you will see, largely dependent on the first, is disturbance of the balance of instincts. By this I mean an over-prominence, an over-irritability of one or more of the instincts in relation to the others. Usually this also is recognizable in very early life and the temperamental sensitiveness just described is always associated with it. Indeed it is the instinctive force that gives sensitiveness specific form.

Usually the instincts of self-preservation, escape and pugnacity—one and sometimes both of them—with their respective emotions of fear and anger, are the moving forces in the second element making for maladaptation. This specific sort of sensitiveness is indeed easy to recognize at an early stage. Who cannot recognize even in infancy the markedly timid or the markedly pugnacious personality in a child? The timid, shrinking child and the irritable, pugnacious child, subject to fits of temper, are too well known both physically and mentally to need further description. The former, I think, is

more apt to be headed for nervousness than the latter, though even the latter, if he be of sensitive temperament, is a neurotic risk.

The training of this element, if not easy, is certainly plain. The child must be taught to acknowledge the presence of the emotion, whether it be anger or fear or whatever. He must learn to treat it not as an enemy, but as a natural part of himself. He must *not* be taught to deny its existence or to make believe through repression that it does not exist. He must be taught to say to himself, "I am mad, or I am afraid, *but* I can *do* as I choose", and he must be held responsible for that choice. Gradually his interest in growing up to be an effective actor, an effective performer of acts of which he approves, must be built up. Coincidentally, good-natured contempt for his own emotions should be established—that is, contempt for the painful element in emotion and sensation. To be a "good sport" rather than a slave of fear or anger must be made an understandable and furthermore an attractive proposition. To make discipline seem always to be self-discipline rather than superimposed I believe to be an important point. Punishment as far as possible, perhaps always, should be to the child an obviously inevitable result of his own action rather than the outgiving of the judgment, backed up by the power, of that superior being, his parent. The parent should stand to him rather as a wise friend whose judgment he believes in and wants to follow than as the strong arm that carries out a little understood law. I believe these rules hold good no matter what overactive instinct we are dealing with, whether it be the instinct of escape, of pugnacity, or even the sex instinct. Our object is to train the child to guide the energies and impulses supplied him by his instincts, not to deny or suppress them, and above all not to be subject or slave to them. In short, the object of training is to make a civilized citizen out of a little, perhaps overly strong, animal.

The third item in the personal equation which needs recognition and calls for training appears later in life than the first two. It has to do with difficulty in realization of the spiritual element where ideals are either unformed or fail in adequate expression because of instinctive or temperamental obstacles.

For lack of a better term, I will call this "character fault" or "weakness". The signs of this tendency are absent from the physical point of view, except, perhaps, in the matter of those indefinite signs of facial expression and form which we rightly or wrongly attribute to strength or weakness of character, such as the "square" jaw, the "loose" lip, or the "wavering" eye. The element, however, can be definitely recognized by a comparison of the individual's behavior with his professed ideals and by noting a prominent feature that is always there —namely, *unreliability*. People with sensitive temperaments and unbalance of instincts always remind me of an electrical apparatus that is suffering from a tendency to short circuit. A person with character faults, on the other hand, resembles an electrical apparatus in which the wires just fail to make connection and the current of energy from the ideal to the apparatus of expression fails to get through. They know theoretically what is right, they are not moral idiots, but they fail to make good their ideals in action with any reliability.

The training of this tendency takes perhaps more tact, more delicacy of touch, and more sympathy than do all the others, for it calls for practical moral training, and by this I do not mean continual punishments or old-fashioned "moral suasion"—though this no doubt has its place—or picturing in lurid colors the "way of the transgressor". It consists rather in showing the adolescent child how his technique has failed, just where a little determination would have made the connection; in showing the practical advantages of regularity, both physical and mental, the efficiencies to be attained by a planned life, the ease to be gained by the momentum of regular habits, and last, but not least, the fundamental necessity to him of contentment above comfort, of happiness above pleasure; and finally in proving that these can be attained only by running the ordinary ideals of life straight through the instinctive apparatus to practical, everyday action.

Irregular Development

There is a fourth type of disorder that tends to nervousness which is important enough to afford a separate classification. The human young, unlike the young of other animals,

tend to develop irregularly. The intellectual side of a child may develop far ahead of the physical and even of the moral. This irregularity is not hard to recognize, especially for the proud parent, who is only too ready to acknowledge precocity of intellect in his own offspring. Unfortunately, only too often the proud parent, instead of turning such a child's energies more toward the development of those elements that are lagging behind—namely, the physical—will in his pride and delight in the child's cleverness push his already over-developed intellect to further precocity. In extreme cases the "infant phenomenon" is developed, who rarely if ever escapes an even more serious breakdown than common nervousness. Obviously the training of such a child should be aimed toward balancing his development by increasing his physical strength and well-being. Out-of-door games and exercises and interest in nature studies should be emphasized, rather than progress in mathematics, woodcraft rather than Latin. All of this can be done without any undue neglect of the purely intellectual development. Indeed it would surely be just the right kind of intellectual development for the physically backward child to turn his interest and reasoning power toward the phenomena of nature and his own growing physical prowess.

When the physical development is obviously ahead of the intellectual, this is easily to be recognized by the fact that the child has to study harder and gets poorer results than the average—usually to the unreasonable despair of his parents. Then the intellectual and moral side of the individuality call for development, but this can be done only gradually, not suddenly. Regularity of life in these cases is particularly important. Such children should be taught to guide the instinctive forces into purposive channels by the gradual introduction of simple, objective, purposive mental effort in relation to outdoor play and exercise, of which such a child is probably already fond. More important even than constructive play is constructive work, both mental and manual, and for such children the educational value of physics, mathematics, and, above all, of manual training, cannot be overestimated. Gradually to stimulate interest in achievement, to arouse gradually curiosity in the "why" of the things in which the child up to then has merely taken animal pleasure,

by stimulating interest in nature and nature's laws, and gradually working through biology to other sciences, is to lead intellectual development on gently till it matches the physical.

When the moral element lags behind, the same method of treatment should be employed as I have roughly outlined as appropriate for character faults. But we should be especially careful not to harden by constant and severe disapproval. We should try in every way to accentuate our appreciation and approval wherever we can find even a slight excuse for it in something well done and for a good purpose. You can always depend upon it that the child will react toward and will be attracted to the pleasurable emotions aroused by approval and praise as readily, at least, as he reacts *away* from the pain of displeasure and disapproval. In short, we must show the child who is backward in moral development that it *pays to be good,* and to do this we must praise every good point; on the other hand, disapproval, when we show it, must be shown only for a purpose and not because we are angry. It is only through the most patient and sympathetic effort that we can hope to make social adaptation seem a worth-while process and a necessity to the morally backward child. To make moral response habitual and reliable must be not only a labor of love, but one of unwavering faith and patience.

Unfavorable Environmental Elements

Modern life, especially the life of the well-to-do, is in many ways poor training, very poor mental hygiene, for the growing child. It presents too much superimposed entertainment. This entertainment, furthermore, has excitement rather than healthful pleasure as its main objective. Movies and theater parties *might* be all very well, but are they? They *might* be opportunities for constructive and instructive play, innocent amusement, and interest, but usually they are not. In the first place, such entertainments are far too frequent in the average child's life, and in the second place, they result in nine cases out of ten not in interest, but in excitement. Coupled with dances lasting to all hours of the night, they constitute an active menace to the child's mental health. The result is that most melancholy sight of modern times—the over-old, blasé

youngster who demands that there shall and must be "something doing" every moment. Through no fault of his own, he has developed within him an abnormal appetite for excitement, on the one hand, and, on the other, a pretty complete ignorance of the real pleasures of play, and unless he is a very evenly balanced, stable individual he is fairly on his way to become a neurotic. Public playgrounds, child athletics, and games in which the real pleasure of play comes from the successful exercise of energy, make for health and stability and not only balance work, but keep the appetite for work, for achievement, alive; whereas movies and modern superimposed entertainment, with only excitement as an unacknowledged goal, make for unbalance, discontent, and nervousness.

A modern child, especially a girl, is dangerously apt to skip from the mental and social age of twelve almost overnight to that of eighteen. This forcing process of modern social life suddenly ejects her from innocent childhood into the status of a society woman. She skips and thus loses utterly those wonderful years of natural fun, of growth of interest, of development of character, of the gradual unfolding of the knowledge of life, those wonderful "teens", which should be lived joyously and as slowly as may be. These should be the years of the most valuable formative training, but too often nowadays are they exploded out of existence by the forced high tension of the modern régime. These years should be guarded, should be utilized for our children's gradual growth and development, and if they are so utilized, they will cheat the nerve specialist of many of his cases.

I have dealt with mental hygiene only where it touches my subject—"nervousness", its causes and prevention. I have spoken of the knowledge already existing, which, if applied, would in my opinion prevent nervousness. Much of this knowledge, you will see, is quite obvious, long known, not original or exciting. True, but that probably is the very reason why it has not been applied. No doubt much of it is too ordinary or too obvious to invite attention, and it has therefore been neglected.

Most often nervousness has its beginnings in childhood; therefore it is in childhood that preventive training should be applied. Obvious, but none the less true.

To summarize, the recognizable symptoms of potential nervousness are:

1. Sensitiveness to the disagreeable and painful.
2. Overbalance of one or more instincts.
3. Faults in application of intelligence and ideal to instinctive forces (character faults).
4. Unevenness in the relative development of the physical, mental, and moral sides during growth.

One or more of these is always the fundamental cause of that maladaptation called nervousness. It is obvious, I trust, that early recognition is not only necessary, but possible in all cases. Obvious or not, it is the truth.

If these tendencies should be and can be recognized, to overcome their influence it is only necessary to train the child accordingly, and this then becomes largely a matter of applying common sense to a clean-cut, formulated problem. To this end all of us, especially parents and teachers, need merely a working knowledge of everyday psychology. It is a simple matter to apply such knowledge in the form of mental hygiene, both to the up-bringing of our children and to the ordering of our own lives.

Prevention in Adult Life

To avoid "nervous breakdowns" in adult life it is necessary only to maintain one's mental and moral efficiency. This can be made a simple, straightforward matter by following a few more or less simple and common-sense rules. These rules can be readily deduced from everyday psychology and common experience. If adopted and applied steadily, they will prove beyond a doubt that "nervousness" can be avoided.

Here follow a few such practical suggestions, more or less formulated specifics against becoming "nervous".

1. Neither run away from emotions nor yet fight them. Accept them as the wellsprings of all action. They are your automatically mobilized energies, and you may, within very wide limits, do with them what you choose. You may furthermore do what you choose, again within broad limits, in the way, in the manner, in which you choose to do it. By doing what you choose, in the way you choose, you force these energies into the channels of your choice. It is like guiding spirited

horses—you guide, they obey, not their own impulses, but your will. A simple suggestion, but if followed, it leads one safely away from the dangers of sensitiveness and unbalance of instinct.

2. Be efficient in what you do. First approve the purpose of the act, then perform that act in a manner and with the means that are appropriate to its purpose. Efficiency or inefficiency is determined by the relation between effort expended and result obtained. Obviously the result must be worth the effort. Nothing is worth doing that is not worth doing *well,* but "well" must include not only the attainment of the gross end in view, but it must also mean attainment without waste of effort. Quality of effort appropriate to the end, skill rather than crude force, means efficiency. In short, do not drive your tacks with a sledge hammer. There is a better, less fatiguing way. Find out how easily you can do things well, and take pride in such skill.

3. Do one thing at a time. Only thus can you practice concentration. By concentration I do *not* mean that violent overdramatization of effort usually understood as concentration, but the gentle art of controlling the attention. This art consists almost entirely of many, oft-repeated, small acts of skillful selection. It is really no more than gently culling from the stream of thought that which is interesting and relevant to the object of the moment and discarding all else. Above all, it is not a violent, sustained moral effort.

4. Make clean-cut, practical decisions. To be clean-cut, they must deal with problems clearly stated and as free from emotional prejudice as may be. To be practical, they must deal with problems of present moment and relevancy, with probability rather than possibility, with the concrete rather than the vague. Finally, decisions must be valued not as irrevocable oaths or unretractable contracts, but as mere decisions, subject to change in the face of new facts or additional knowledge.

5. Do not accept hurry as a necessary part of modern life. If hurry in any given case becomes necessary, it has become so solely because there has been a direful lack of plan, or because tardiness and procrastination have spoiled the plan, or lastly because one has tried to crowd two or more things

into the temporal space of one. Quality of work, not quantity, spells success, and quality is destroyed by hurry.

The worst enemy of efficiency, as well as the best ally of nervousness, is worry. Worry is a complete circle of inefficient thought whirling about a pivot of fear. To avoid it, consider first whether the problem in hand is actually your business. If it is *not,* turn to something that is. If it is your business, decide next whether it be your business now. If it be your business and your business now, decide what is the wisest and most efficient thing to do about it. If you know, get busy and do it; if you do not know, if you lack knowledge, seek the knowledge you need and seek it now. Do these things, and in nine cases out of ten, anxiety will not degenerate into worry. If the actual probabilities are so very bad that intense anxiety is unavoidable, nevertheless, apply this mechanical rule, and then assert your faith and your courage: realize that success, for you as for others, is always approximation of the ideal; then rest your case on the determination that no matter how hard things may turn out to be, you will make the best of them, and more than that no man can do. In short, common sense can put worry out of the running in most cases, but always faith is essential to real victory.

7. Keep work, play, rest, and exercise in their proper relative proportions, not only in the space of decades, but year by year, month by month, week by week, and day by day. Keep these items separated. Work when you work, play when you play, and do nothing when you rest. Each item has its *daily* place, and a well-planned life is a life made up of well-planned days. Such a life absorbs emergencies without strain.

8. Shun the New England conscience. It is a form of egotism that makes a moral issue of every trivial thought or feeling. Its motive is self-defense, defense of self from the possibility of guilt or consciousness of moral error. It takes the adventure out of life and fills it instead with endless petty, safety-first devices, clogging its machinery and warping it out of true. To live fully and with reasonable ease, one must take one's own fundamental decency more or less for granted, and be willing to take at least ordinary chances of being wrong. Soul-harrowing analyses to prove one's moral impeccability are expressions of nothing better than worry about self, and the same rules apply to this sort of worry as to all other sorts.

9. Energy is often wasted by a peculiar process which many people seem to think necessary before they can do anything, especially anything that promises to be difficult. I refer to a sort of "getting up steam", a kind of moral mobilization, an attitude of "girding up the loins" mentally speaking, which is referred to by them as "making up their minds", or "getting ready" to do something. It is not a decision, but usually follows one as a sort of preliminary flourish before action. It is really only picking up a moral sledge hammer, and an imaginary one at that, when a practical decision has already cleared the way and nothing remains to be done save to begin immediate action. When a decision has been reached, when something has to be done, waste no time in mobilizing extra energy—just do it.

10. Lastly, to avoid breaks in character, breaks between your ideals and your everyday actions, recognize that your problem is fundamentally the same as every one else's, no matter what your particular job may be. This problem of ours, reduced to its common denominator, is to keep our ideals clear, to adopt purposes that shall serve these ideals, and lastly to make our ideals live in practical, purposive, everyday action. To do this, it is first necessary to accept the material of life as good enough for us, as definitely *our* material, awaiting only our workmanship to be forged into success. This should be our method of making our dreams come true, of living up to our great illusion. Therefore, waste no time in kicking against the pricks. The "divine unrest" of ambition is a noble spur to better action, but the restlessness of discontent is a miserable state of misunderstanding. Beware the contrary currents of anger, fear, and pride, but turn the strength of these currents into the channels of your purposes. Do not criticize your part in the play; study it, understand it, and then *play* it, sick or well, rich or poor, with *faith,* with courage, and with proper *grace.*

To follow these rules absolutely and to the letter is certainly somewhat beyond the power of human frailty, but to follow the spirit, to steer one's course by some such compass, is both possible and practical. Thus and only thus can one maintain a good, safe offing from the shoals and reefs of nervousness.

THE SOCIAL SIGNIFICANCE OF DEMENTIA PRAECOX*

EDITH M. FURBUSH
Statistician, The National Committee for Mental Hygiene

MENTAL diseases have been divided into certain large and more or less definite groups, on the basis of their symptoms, course, causes, and other important characteristics. These groups are not always enclosed by rigid boundaries, but, like some of the main groups of general diseases, often overlap, and an individual patient who seems at first to belong in one group is not infrequently found later to belong in another. One of these groups of mental diseases is dementia praecox. The name suggests two of its chief characteristics —tendency toward mental deterioration and relatively early age of onset. Allowing wide latitude for individual medical opinion, different clinical aspects presented by the same patient in the different phases of the disease, and a fairly high proportion of atypical cases, patients with dementia praecox represent a section of the population of hospitals for mental diseases definite enough, large enough, and important enough to make some facts regarding them have great medical, sociological, and economic importance.

Dementia praecox occupies a distinctive place among the various groups of mental disease. It is more perplexing and more baffling than any other form. As many persons afflicted with this disorder enter hospitals early in life and remain there until old age, there has been a continuous accumulation of dementia-praecox patients, with the result that they now constitute the largest single institutional problem in this country. They outnumber patients with all other forms of mental disease combined. They are twice as numerous as persons in hospitals for the treatment of tuberculosis. They exceed the total population of all institutions for the feebleminded and epileptics and state prisons.

* The author wishes to acknowledge the assistance of Dr. Horatio M. Pollock, Statistician of the New York State Hospital Commission, particularly in preparing the portion of this article relating to economic cost.

On January 1, 1920, there were 232,680 patients with mental diseases in institutions in this country.[1] No enumeration was made by psychoses that would show the number of persons with dementia praecox in this group. However, a census of the patients in the state hospitals in New York on June 30, 1920, showed that 59 per cent were cases of dementia praecox. The percentage for the country as a whole would be somewhat lower, as the patients in New York represent the accumulation of many years. Other things being equal, the older the institution, the higher is the ratio of dementia-praecox patients to the total number. A conservative estimate of dementia-praecox cases among patients in hospitals for mental diseases in this country at the present time would be 55 per cent. This means that there are approximately 130,000 persons with this form of mental disease in these institutions. On account of the absence of marked psychotic symptoms, a large number of persons with this form of mental disease never reach hospitals, but are in the community as loafers, beggars, and tramps, or swell the population of penal institutions and almshouses.

Of 21,012[2] patients with mental diseases admitted for the first time to 72 state hospitals during the year 1920, 5,676, or 27 per cent, were cases of dementia praecox. During that year there were approximately 50,000 new admissions with mental diseases to all hospitals devoted to their care. On this basis the number of new cases of dementia praecox reaching hospitals for mental diseases is more than 13,000 annually. In other words, in dementia praecox we have a form of mental disease that at the present time requires the institutional treatment of at least 130,000 persons, and each year causes the withdrawal from society into these institutions of over 13,000 new cases.

The question naturally arises: What of those persons with dementia praecox who are returned to the community from

[1] *Patients with Mental Disease, Mental Defect, Epilepsy, Alcoholism and Drug Addiction in Institutions in the United States, January 1, 1920.* By Horatio M. Pollock and Edith M. Furbush. MENTAL HYGIENE, Vol. 5, pp. 139-69, January, 1921.

[2] *Comparative Statistics of State Hospitals for Mental Diseases, 1920.* By Horatio M. Pollock and Edith M. Furbush. Published by the Bureau of Statistics, The National Committee for Mental Hygiene, 1922.

hospitals each year? During the year 1920, there were 3,668 cases of dementia praecox discharged into the community from 69 state hospitals, 10 per cent of whom were discharged as recovered, 67 per cent as improved, and 23 per cent as unimproved. These patients represented 27 per cent of the total number discharged from these institutions. The number of patients discharged from all hospitals for mental diseases has been estimated at 32,000 annually. The dementia-praecox patients among these discharges would, therefore, approximate 8,600. Large as this number may seem, it must be remembered that the great majority do not become independent, self-supporting citizens and that a considerable number later return to hospitals as readmissions. During the year 1920, there were 5,276 readmissions to 70 state hospitals. Of this number 1,722, or 33 per cent, were cases of dementia praecox. On this basis, among the 14,000 readmissions to state hospitals each year, there would be over 4,500 dementia-praecox patients.

Of the 5,676 new cases of dementia praecox admitted to 72 state hospitals in 1920, 3,144 were males and 2,532 were females. In other words, there were 124 males for each 100 females. The number of males per 100 females in the general population of this country on January 1, 1920, was 104.

With respect to age, it was found that of each 100 new admissions with dementia praecox, 8 entered the hospital before reaching the age of twenty years, 40 between twenty and thirty, and 32 between thirty and forty; the remaining 20 were forty years of age or over at the time of admission. That 52 per cent were thirty years or over at the time of admission may be explained by the fact that in many instances a long interval elapses between the onset of this disease and admission to a hospital. Marked differences appeared in the age distribution of the two sexes. Fifty-six per cent of the male cases and only 38 per cent of the female cases were under thirty years of age at the time of admission; 87 per cent of the males and 71 per cent of the females were under forty years of age. The percentages of males and females between the ages of thirty and forty were almost the same.

The degree of education of these admissions may be of in-

terest. Of each 100 cases whose degree of education was ascertained, 7 were illiterate, 25 were able to read and write only, 56 had a common-school education, 10 had attended high school, and 2 had attended college.

As regards environment, it was found that 73 per cent came from urban communities and only 25 per cent from rural districts, while the environment of 2 per cent was unascertained. The environment of the United States as a whole is 51 per cent urban and 49 per cent rural. The terms urban and rural are used as in the United States census classification, urban applying to places having a population of 2,500 or over, all other places being considered as rural.

A study[1] of first admissions to state hospitals during 1919 showed that the rates for dementia-praecox first admissions per 100,000 of general population of the same environment were as follows: urban 19.4 and rural 9.5. These figures differed considerably from the rates found for the other psychoses, as shown by the following summary:

Environment of First Admissions to State Hospitals

PSYCHOSES	RATES PER 100,000 OF POPULATION OF SAME ENVIRONMENT	
	Urban	Rural
Senile	7.2	5.4
With cerebral arteriosclerosis	3.3	1.4
General paralysis	8.6	2.0
Alcoholic	2.8	0.6
Manic-depressive	10.5	6.8
Dementia praecox	19.4	9.5
All psychoses	68.2	36.0

The excessively high rate of dementia praecox in cities may be due to some or all of the following factors: stress of city life on persons unfavorably situated, complicated city life making it more difficult even for milder cases to adjust to their environment, milder cases being brought to the attention more generally in urban than in rural communities, some-

[1] *Mental Diseases in Twelve States, 1919.* By Horatio M. Pollock and Edith M. Furbush. MENTAL HYGIENE, Vol. 5, pp. 353-89, April, 1921.

thing in the nature of the disease itself that makes it essentially prevalent in urban communities, or something in the nature of persons who develop the disease that makes them seek an urban environment.

In a study[1] of 9,024 dementia-praecox patients admitted to the New York state hospitals from October 1, 1911, to June 30, 1918, Dr. Horatio M. Pollock found that the rate of incidence of dementia praecox was much higher in urban than in rural districts, and that the rate was higher in large cities than in small ones, but that individual exceptions seemed to indicate that the size of the city was not a dominant factor.

With respect to the economic condition of dementia-praecox first admissions to state hospitals throughout the country during 1920, it was found that of each 100 cases, 18 were reported as "dependent", 63 as "marginal", and 19 as "comfortable". The corresponding figures for all other psychoses were 21, 54, and 25. These terms are thus defined: "dependent", lacking in necessities of life or receiving aid from public funds or persons outside the immediate family; "marginal", living on daily earnings, but accumulating little or nothing, being on the margin between self-support and dependency; and "comfortable", having accumulated resources sufficient to maintain self and family for at least four months.

Comparatively few patients with dementia praecox are intemperate users of alcohol. Of each 100 cases whose alcoholic habits were ascertained, 54 were abstinent, 35 temperate, and 11 intemperate. The corresponding numbers for all other forms of mental disease were 54, 30, and 16.

Of each 100 cases of dementia praecox whose marital condition at the time of admission was ascertained, 61 were single, 31 were married, 4 were widowed, 2 were separated, and 2 were divorced. The following summary gives the corresponding percentages by sexes:

1 *Geographical Distribution of Dementia Praecox in New York State.* By Horatio M. Pollock. *The State Hospital Quarterly*, Vol. 4, pp. 312-24, May, 1919.

Marital Condition of First Admissions with Dementia Praecox

MARITAL CONDITION	NUMBER		PER CENT	
	Males	Females	Males	Females
Single	2,401	1,100	75.0	43.2
Married	649	1,131	20.3	44.4
Widowed	67	196	2.1	7.7
Separated	36	59	1.1	2.3
Divorced	47	63	1.5	2.5
Total ascertained	3,200	2,549	100.0	100.0

The differences in percentages are noteworthy. Particularly striking is the large percentage of single men. This is accounted for in part by the fact that the onset of this form of mental disease occurs at an earlier age among males than among females, and in part by the fact that women as a rule marry younger than do men. There are doubtless other factors to account for this large percentage.

The foregoing social facts were obtained from uniform tabular forms received from state hospitals throughout the country. Other data such as occupation, temperamental make-up, nativity, and race are worthy of consideration. A detailed study[1] of the occupations of new admissions with dementia praecox to the New York state hospitals from October 1, 1909 to June 30, 1916, including a total of 7,026 persons, demonstrated that they came from all branches of industry, that the rate was higher in indoor than in outdoor occupations, and that there was a high rate in occupations requiring close application with accompanying eye strain. It was found that a disproportionate number of female patients came from domestic and personal service, that the average rate among employed women was higher than among employed men, but that in clerical service the rate was higher among men than among women.

In the report of the New York State Hospital Commission for the year that ended June 30, 1920, the 1,926 new admissions with dementia praecox were classified with reference to temperamental make-up. Of these patients 29 per cent were

[1] *Occupation and Dementia Praecox.* By William J. Nolan. *The State Hospital Quarterly*, Vol. 3, pp. 127-154, February, 1918.

reported as temperamentally normal prior to the onset of the disease, 44 per cent as temperamentally abnormal, and 27 per cent as unascertained. The largest group of the cases reported as temperamentally abnormal were of a seclusive make-up. Other groups were classified as depressive, unstable, suspicious, egotistical, irritable, sexually abnormal, and criminalistic.

As regards the race of these same persons with dementia praecox admitted to the New York state hospitals, it was found that the Irish contributed the largest number of any one race—16 per cent—followed by the Hebrew race with 12 per cent, the German with 11 per cent, and the Slavonic and Italian races each with 10 per cent. The following summary shows the percentage of dementia-praecox cases among the first admissions of each race:

Race of First Admissions with Dementia Praecox, New York State Hospitals

RACE	TOTAL FIRST ADMISSIONS	DEMENTIA PRAECOX	
		Number	Per cent
African	255	85	33.3
English	340	51	15.0
German	770	216	28.1
Hebrew	693	229	33.0
Irish	1,086	304	28.0
Italian	563	185	32.9
Slavonic	407	190	46.7
Mixed	1,589	403	25.4
Other races	548	191	34.9
Unascertained	322	72	22.4
Total	6,573	1,926	29.3

In a study[1] of dementia-praecox first admissions to the New York state hospitals from October 1, 1911 to June 30, 1918, it was found that the rate per 100,000 of general population among the foreign born was higher than among the native born. The foreign born came principally from Austria, Germany, Hungary, Ireland, Italy, and Russia. The

[1] *Sex, Age, and Nativity of Dementia Praecox First Admissions to the New York State Hospitals, 1912 to 1918.* By Horatio M. Pollock and William J. Nolan. *The State Hospital Quarterly*, Vol. 4, pp. 498-516, August, 1919.

following summary presents the number and rate per 100,000 of general population of the same nativity for each of these countries as determined from this report:

Nativity of First Admissions with Dementia Praecox, New York State Hospitals

NATIVITY	NUMBER	RATE
Austria	598	244.1
Germany	488	111.7
Hungary	240	247.8
Ireland	528	143.5
Italy	528	111.8
Russia	886	158.5

Of the 2,414 dementia-praecox patients who died in 74 state hospitals throughout the country during 1920, 36, or 1 per cent, were under twenty years of age; 371, or 15 per cent, were from twenty to thirty; 564, or 23 per cent, were from thirty to forty; 432, or 18 per cent, from forty to fifty; 407, or 17 per cent, from fifty to sixty; 333, or 14 per cent, from sixty to seventy; and 262, or 11 per cent, were seventy years and over. In the case of 9 the age at death was not ascertained.

Of more significance than the age at death of these patients is their length of hospital residence. It was found that of each 100 deaths, 14 had a hospital residence of less than one year; 22, more than one, but less than five years; 19, from five to ten years; 19, from eleven to nineteen years; and 26 for twenty years or over. Similar percentages by sexes are shown in the following summary:

Hospital Residence of Patients with Dementia Praecox Dying in State Hospitals

HOSPITAL RESIDENCE	PER CENT	
	Males	Females
Under 1 year	12.4	16.5
1 to 4 years	24.0	20.5
5 to 10 years	19.6	17.7
11 to 19 years	17.9	19.8
20 years and over	26.1	25.5
Total	100.0	100.0

A comparison of the average length of hospital life in the principal psychoses of patients who died in the New York state hospitals during 1920[1] may be of interest:

Average Length of Hospital Life in Principal Psychoses, New York State Hospitals

PSYCHOSES	AVERAGE LENGTH OF HOSPITAL LIFE
Senile	2.0 years
With cerebral arteriosclerosis	0.9
General paralysis	1.2
Alcoholic	7.6
Manic-depressive	3.7
Involution melancholia	3.3
Dementia praecox	14.7
Paranoia or paranoid conditions	12.3
Epileptic psychoses	10.3

It will be seen from the above that dementia-praecox patients remain in hospitals longer than any of the other groups, four times as long as manic-depressive patients, twice as long as persons with alcoholic psychoses, and over twelve times as long as patients with general paralysis.

The causes of death of patients with dementia praecox who died in state hospitals throughout the country during 1920 were as follows: 1,065, or 44 per cent, from general diseases; 191, or 8 per cent, from diseases of the nervous system; 473, or 20 per cent, from diseases of the circulatory system; 303, or 13 per cent, from diseases of the respiratory system; 173, or 7 per cent, from diseases of the digestive system; 158, or 6 per cent, from diseases of the genito-urinary system; and 51, or 2 per cent, from other causes. The following summary gives the principal causes of death:

[1] Thirty-Second Annual Report of the State Hospital Commission, July 1, 1919 to June 30, 1920. Albany, 1921.

Causes of Death of Patients with Dementia Praecox Dying in State Hospitals

CAUSE OF DEATH	NUMBER	PER CENT
Tuberculosis of lungs	786	32.6
Other forms of tuberculosis	56	2.3
Cancer	65	2.7
Apoplexy	66	2.7
Myocarditis	171	7.1
Endocarditis	125	5.2
Arteriosclerosis	85	3.5
Bronchopneumonia	123	5.1
Lobar pneumonia	140	5.8
Diarrhea and enteritis	70	2.9
Nephritis	141	5.8
Other causes	586	24.3
Total	2,414	100.0

It may be of interest to know that 16 committed suicide and 2 deaths were due to homicide.

It has been estimated that about 30,000 persons die annually in hospitals for mental diseases. In the group of hospitals studied, persons dying with dementia praecox constituted 21 per cent of the total deaths during the year 1920. If this percentage holds good for the remaining hospitals, over 6,000 patients with dementia praecox die annually in hospitals for mental diseases in this country.

Turning from the social to the economic aspects of dementia praecox, the question arises: What is the economic loss to this country on account of dementia praecox? The economic loss on account of any mental disease consists of two principal factors—namely, the cost of maintenance of persons having the disease and the loss of earnings due to their incapacity. Other minor factors are involved, such as expenses incurred by relatives of patients and losses due to the sudden disruption of the patients' business relations. The latter items cannot be measured and there are no data from which satisfactory estimates may be made.

The average per capita cost of maintenance of patients in 72 state hospitals during the fiscal year that ended in 1920

was approximately $315.[1] This amount does not include interest or depreciation on hospital plants. Other studies have shown that the per capita investment in buildings and personal property necessary for the care of patients is approximately $1,000. Assuming this amount to be the average for the country as a whole and computing interest at 5 per cent and depreciation at 2 per cent, the annual investment charge per patient would be $70. This amount added to the maintenance cost would make the annual per capita cost of hospital care for patients $385. On this basis the total yearly per capita cost of the 130,000 dementia-praecox patients under treatment in hospitals at the present time would be $50,050,000.

Dementia praecox is a malady from which very few persons fully recover. It is true that many patients improve under hospital treatment and are discharged, but a large majority are not able to earn more than enough to support themselves while outside the institution, and many are partly dependent upon relatives. Some dementia-praecox patients do productive work within institutions, but as such work reduces the cost of maintenance, it is taken into account in part by the use of the net maintenance cost in these computations. Assuming that the average discharged dementia-praecox patient earns only his maintenance, the economic loss on account of earnings at the time of the first admission of a dementia-praecox patient would be the present worth of the probable future net earnings of a healthy person of the same age during the balance of the productive period of life. It is assumed that the period of productivity ends at the close of the sixty-fifth year and that the average earnings are the same throughout the years of productivity. The average per capita earnings of males above the cost of maintenance are estimated at $500 a year and those of females above cost of maintenance at $100.

The number of dementia-praecox patients annually admitted for the first time has been estimated at 13,000 (page 289), of whom 6,800 have been assumed to be males and 6,200 females. These figures conform closely with the ratios found in previous studies. These first admissions are classified ac-

[1] *Comparative Statistics of State Hospitals for Mental Diseases, 1920.* See note 2, page 289.

cording to age, and the loss of earnings at each age is taken to be the present worth on a 4 per cent basis of the total estimated future earnings during the period of productivity. The annual loss of earnings on account of the onset of dementia praecox among males, computed in this manner,[1] amounts to $62,900,000, and that due to the onset of dementia praecox among females to $10,700,000.

The annual economic loss to the nation on account of dementia praecox may therefore be summarized as follows:

Total annual cost of maintenance in institutions.	$ 50,050,000
Loss of earnings, males	62,900,000
Loss of earnings, females	10,700,000
Total	$123,650,000

The magnitude of the cost—both social and economic—of dementia praecox urgently calls for preventive action. What can be done to reduce the extent of this disorder and the resulting losses? The following lines of action are indicated: first, intensive research directed toward a more thorough understanding of the nature of the disease itself, and second, a more *active application of existing knowledge,* with a view to restoring to the community an increasing number of dementia-praecox patients and to identifying a larger number of potential cases in the community before marked psychotic symptoms have developed.

[1] For a more detailed account of the method of computation see *The Economic Loss to the State of New York on Account of Syphilitic Mental Diseases During the Fiscal Year Ending June 30, 1917.* By Horatio M. Pollock. *The State Hospital Quarterly,* Vol. 3, pp. 241-46, May, 1918.

MENTAL HEALTH AND THE NEWSPAPER*

NELSON ANTRIM CRAWFORD

Professor of Industrial Journalism, Kansas State Agricultural College

THE ideal of mental health and the ideal of the newspaper are properly the same. Truth is the ideal of both. Mental ill health is invariably associated with a variation from truth. It is not necessary that a person have delusions, hallucinations, or fixed ideas in order to depart from the truth. Truth involves every phase of life—physical, intellectual, and emotional, to use an old classification. The mental attitude of a person affected with a phobia or a psychoneurosis is by that fact so directed to one aspect of life—and not infrequently an aspect of life that is no longer of race service—that he fails to preserve a proper balance with reference to the other aspects of life, which invariably are more important. Every mental disease, however slight, involves in some measure a distortion of the truth. With our knowledge of the remarkable widening of the range of mental disease by psychological discoveries, we are probably safe in stating also the converse of this theory—that every distortion of the truth is traceable, directly or indirectly, to some form of mental distortion or pathology.

The ideal of the newspaper is, as its name indicates, to present the news—that is, to state objective facts accurately, fairly, and understandably. With the development of modern science, investigation, and industry, many apparently objective facts have no vital meaning for the average reader without expert interpretation. If the newspaper is to be what it should be, in accordance with its ideal as an organ of the truth, it must, where necessary, resort to expert interpretation, being careful that such interpretation is just and unbiased. The newspaper resorts regularly to interpretation—not always expert, however—of political and economic problems. It resorts to expert interpretation of scientific matters related to industry. Unfortunately, it almost never employs

* Read before the Annual Meeting of the Kansas Society for Mental Hygiene, Topeka, December 8, 1921.

expert interpretation of psychological and psychiatric problems. By resorting to expert interpretation of these problems, it could educate the public to an understanding of many abnormalities that are a constant menace, but concerning which the average reader has no dependable knowledge.

Particularly in the field of criminology is this important. Our methods of dealing with crime, though less barbarous and more kindly, are little more sensible, so far as the habitual criminal are concerned, than the methods of many years ago. There is a prevalent belief that habitual crime is due to intellectual ignorance. As a matter of fact, it is due to nothing of the sort. Habitual crime is in large part, if not entirely, the result of organic or functional mental disease. Education of the intellect is no cure for this. This becomes at once obvious when one considers the fact that the world's leaders in statesmanship, in art, in invention, and in other fields have not infrequently been psychopathic, though not for the most part in a criminal direction. The same theory holds good with respect to the criminally psychopathic. The cure must be prescribed by the psychiatrist rather than by the educator.

The psychological disorders that are promotive of crime will not be cured until the public gains an understanding of these disorders, and the newspaper is the only medium through which the general public will be able to gain such an understanding, for the newspaper is all that it reads. The popular reaction to discussion of the relation of crime to mental disease is that too many persons are acquitted of murder, for instance, on the ground of insanity. The public is palpably wrong. Not fewer, but more, murderers are insane than have been declared insane by the courts. If, however, there were an intelligent grasp of the facts of mental disease, the condition of these persons would have been recognized and they would have been cured or restrained before they had had opportunity to commit murder. In this campaign of education the newspaper can be of marked service.

Probably the most dangerous situation, so far as criminology is concerned, is the public ignorance concerning sex and sex crimes. When sex crimes occur, the average newspaper and the average reader shout such terms as "fiend" and "degeneracy". They feel the common repugnance to the unnatural or the abnormal, and see in persons guilty of sex

crimes a wilful moral guilt. As a matter of fact, sex crimes are almost invariably, if not absolutely invariably, the result of definitely recognized psychopathies, and psychopathies are cured neither by imprisonment nor by any other punishment. The mob that lynches a prisoner for a sex crime merely bears witness to a sexual aberration of its own. There is a strong sadistic component in the mental life of the race, and the members of the lynching mob are simply giving vent to this psychopathological condition in themselves.

To the improvement of conditions in these respects the newspapers and magazines are doing little or nothing. It is an astounding fact that in the various trials in which Harry K. Thaw was involved and concerning which certain newspapers published such revolting details that they were threatened with criminal prosecution, no newspaper or magazine, to the best of my knowledge, published a sound, understandable explanation of the sexual psychopathy with which Thaw was and is afflicted, or discussed the means of guarding against the menace of this condition in human life.

Again, in all the stories that appeared in the Kansas City papers last summer concerning a "vice ring" in that city, there was line after line of suggestive material that might easily cause a boy or girl to wish to delve further into the type of vice represented, but there was not a line in any newspaper in that city that gave a rational explanation of the sexual inversion with which the leaders of this ring were afflicted, or the proper psychiatric method of handling such cases. The leaders of this vice ring are presumably complete inverts. Whether one holds that this character is inherited, or maintains with the Freudian school that it is acquired in infancy or early childhood, the fact remains that the individual so afflicted is frequently incapable of self-restraint and the mental disease itself is of doubtful curability at the present time. The danger to society from persons of this type is that they may engage in abnormal practices with persons who are at least partly normal and may develop in them serious neuroses. It is dangerous to the other inmates of a prison that men of this type be confined with them. The method that most psychiatrists would suggest would probably be confinement in a psychopathic hospital, where studies might be made to discover, if possible, a cure for the abnor-

mality. So long as sex crimes are placed on the basis of wilful moral turpitude, they are bound to occur again and again; the vice ring of Kansas City will be repeated in other cities, perhaps in Kansas City itself. When the people once understand such psychopathies, however, they will take sensible steps, through greater care in breeding, to prevent psychopathic inheritance; they will be solicitous as to the early life of children; and when psychopathic conditions do develop, they will handle them from the point of view of science and not that of the ignorant rabble.

In this the newspapers can, if they will, be of enormous practical service. They are the popular educators of the day. No false modesty or fear of shocking popular prejudices should prevent the newspapers, when crimes that justify it are committed, from interpreting, scientifically and intelligently, what has actually taken place and what can be done to prevent its recurrence.

Not only in such extreme cases, but in the matter of the more common disorders, may the newspapers be of service. A physician in Kansas City has told me that public sentiment is so uninformed that it would be impossible in that town to enforce the state law regarding the segregation of the feeble-minded. The public does not understand the importance of this measure and the newspapers should inform it.

The other relationship of the newspapers to mental health that I wish to discuss is a much more complex one. It involves the basis of many psychopathies, not only individual, but national and racial. That basis is fear. Fear is still one of the most potent forces in human conduct.

Fear is a characteristic of the newspapers and of the American people at the same time. It is not physical fear, for Americans have shown courage and endurance times without number. It is rather intellectual and spiritual fear, based on nothing that affords a reasonable basis for fear. It is, in short, psychopathological fear, as clearly such as fear of an open space or fear of a cat. Most conspicuously it takes the form of fear of and deference to the herd, the whole body of people. Necessary for the preservation of the race at some distant period, this phobia is preserved as a psychopathological anomaly in the United States of America to-day.

Pathological fear always masks or rationalizes itself in other guises. No individual is willing to admit, even to himself, that he is a coward. The fear "complex" is inhibited by the psychic "censor" and manifests itself in indirect and devious ways. Conduct actually inspired by fear is explained on the basis of various false rationalizations.

The newspaper, as at present constituted, is essentially a herd institution. And the herd in the United States is a very closely massed formation, held together by a great body of beliefs and taboos. One of its most marked characteristics is its fear of and hostility to new ideas. The American public does not want facts; it wants only pleasant facts.

The newspapers, generally speaking, defer to the American public's fear of ideas. The herd fears ideas; the newspaper fears the herd; therefore, the newspaper fears ideas. Thus is established a vicious circle of psychopathological fear.

The newspaper's fear seems in some cases justified. When a paper does publish facts that tend to conflict with herd dogmas, the herd often manifests its resentment by canceling subscriptions, stopping advertising, or at the least writing letters expressing regret that the newspaper should tell a truth of which the herd disapproves. Amusing—isn't it?—and at the same time tragic that people can think of truth as something that may be approved or disapproved!

At the same time, many a newspaper consciously encourages the herd's fear of ideas by suppressing, distorting, or coloring the facts in such a way as to give a wholly different impression from that which the facts, objectively and honestly stated, would give. I have heard newspaper men seriously question whether the public ought to be given this or that fact. As if in a democracy the people were supposed to govern in ignorance of the facts or in possession of facts distorted by interested persons!

Until pathological fear is eliminated from American life, we shall have neither mentally healthy individuals nor a mentally healthy nation. To eliminate this type of fear, the coöperation of the newspapers is essential. The chains binding the newspaper to the herd, the chains binding the herd to a fixed deposit of tradition and taboo, must be broken. Through the influence of journals of opinion, of open forums, of educational institutions, of liberal movements of all sorts,

more and more men and women are breaking away from the herd dogmas. They furnish a nucleus to which newspapers willing to stand for the truth regardless of popular opinion may appeal. If a sufficient number of leading newspapers will break away from their fear of the herd, they can accomplish more than any other institution to destroy the attitude of fear that tends to paralyze American thought and life.

To sum up, the newspaper has the same ideal as the seeker for mental health. That ideal is truth. The newspaper can aid in the establishment of higher standards of mental health in the nation, first, by interpreting to the people the mental diseases that predispose to crime or other antisocial activity; secondly, by aiding, both through precept and example, in the elimination of those pathological fears that are so marked and sinister a characteristic of American life.

A SOCIAL-SERVICE DEPARTMENT IN A STATE HOSPITAL

MARIE L. DONOHOE
Head Social Worker, Boston State Hospital

SOCIAL service has been established in the state hospitals of Massachusetts for a sufficient period of time to prove its value both to the hospitals and to the community. There would seem to be no longer a question that a social-service department, properly equipped, is essential if a hospital is to fulfill its obligations adequately and is to dispense economically the private or public funds at its disposal. The experience in Massachusetts has been sufficiently long, furthermore, to warrant some conclusions as to the type of organization that should be planned for a social-service department in a state hospital. At least this is clear—for adequate work there must be an adequate staff. In Massachusetts patients are discharged from the state hospital on trial visits of one year, and during this year the social-service department of the hospital is held responsible for the patient. But if this supervisory care in the community is to be adequate, it is obvious that there must be a sufficient corps of workers. If a problem arises in the community in relation to a patient, it is the social-service department that receives the criticism if the problem is not handled efficiently. But such problems are too numerous to be handled by one or two workers. Dr. Henry P. Frost, the late superintendent of the Boston State Hospital, said in his report of 1915: "The service is most valuable, but its possibilities are merely indicated, not realized by the single worker so far available." But there is a larger question involved than the criticism of a department. A patient on visit is still legally under the care of the hospital—although the hospital cannot care for the patient. One may ask, therefore, what moral right has a hospital to claim legal rights over its patients in the community if it cannot give these patients supervision and care when they are needed.

After an association of six years with two state hospitals

in Massachusetts, I present the following plan as a good working department in any large state hospital:

SOCIAL-SERVICE DEPARTMENT IN A STATE HOSPITAL

I. *Chief of Social Service.*
   a. To organize.
      Plan the character of the work.
      Limit the extent of the work.
      Know the assistance needed in the department.
      Know the ways of obtaining this assistance.
   b. To represent social service in the out-patient department.
   c. To do educational work.
      Lectures outside the hospital, to organizations, clubs, students.
      Lectures to the nurses of the hospital.
   d. To train student and volunteer workers.

II. *Historian*
   a. To take medical histories during absence of the physicians.
   b. To take social histories on every case.
   c. To sort all admissions, referring to the chief all cases that need social-service care.
   d. To do some of the investigation for diagnosis.

III. *Social Case-workers.*
   a. Ward social worker at the hospital.
   b. Boarding-out visitor. (Each hospital should have absolute charge of its boarding cases.)
      To visit the patients when boarded.
      To enlarge this department, finding opportunities to make it grow.
      To do some medical follow-up work.
   c. Case-workers (two at least).
      To do the investigating for diagnosis.
      At least two workers to arrange for the care of the patients in their own homes and to give intensive care of the patients during trial visit.
      To carry the family through the difficulties of the patient's hospital residence.
      To plan for the patient's return when necessary.
   4. Employment worker.
      To investigate opportunities for the employment of patients on visit.
      To supervise patients when employment is found.
   e. Syphilis worker.
      To work with the families of all patients who are admitted showing symptoms of syphilis.
      To follow up all patients who leave the hospital and attempt to see that treatment is received in cases recommended by the medical staff.
   f. Case-worker in the out-patient department.
      To do the case-work of those patients who come to the clinic and need social care.

IV. *Clerical Assistants.*
   a. Office manager and secretary to chief.
   b. Stenographer.
      Filing, record writing, etc.

I. *The Chief.*

The chief should be directly responsible to the superintendent for the policies of her department. She should be responsible for the entire organization of the department. She should plan and distribute the work and limit its extent. She should have the privilege of refusing to accept cases that do not rightly belong to the social service. She should know what assistance is needed for conducting the department properly and should be acquainted with ways of obtaining assistance when it is needed. The chief of the service should have control of all social work done in the out-patient department. The actual case-work she should delegate to the case-worker in the out-patient department, but all cases accepted for social care should be approved by the physician in charge of the out-patient department and the chief of social service. Educational work in the community comes under the duties of the chief. Lecturing before physicians, nurses, clubs, and students of social work should be considered a part of her work. The training of students and volunteer workers should also be one of her duties. All research work done in the department should be under the direct supervision of the chief.

II. *Historian.*

In my opinion, the historian rightly belongs under the chief of the social service. She should be as well trained in taking good medical histories as she has been trained in taking good social histories. Every patient should, on admission, have a careful social history taken as well as a careful medical history. Every mental patient is potentially a social-service case. In a study made recently by a student worker at the Boston State Hospital, it was found that the majority of cases that came to the department for slight service were later taken on for intensive social care. At the present time, we realize that admission or commitment to a state hospital has been sought by the family or friends almost as a last resort. We are still dealing with an unenlightened public as far as mental illness is concerned. The educational work that can be done with the families of patients at the time of admission to the hospital is unlimited. Careful, direct information about the hospital—its functions, its rules, its aims, its treat-

ment—given to the family, brings to them comfort and relief and, in return, the hospital gets the benefit of intelligent interest, coöperation, and appreciation. An hour well spent at the time of admission saves the doctor many hours of explanation and the family of the patients many moments of worry and unhappiness. The historian should refer to the chief all cases that need social-service care.

III. *Social Case-workers.*

a. Ward social worker. There is, I feel, a definite need in every state hospital for the services of a social worker with the patients on the wards. Some link to connect the patient with his family and the outside world is necessary as part of the treatment. We all know that there are numberless patients in our state hospitals whose greatest need is some form of reëducation. Some of this work of reëducation is, of course, done by the psychiatrist. The doctor, however, has not the time, the patience, or the training to do all this work, nor is he likely to have an adequate knowledge of the situation outside the hospital. A specially trained worker who understands the patient's case, who is well versed in the community's resources, and in the particular problems of the patients, can do this work even more efficiently than the doctor. All this work done in the hospital, however, must be done under the close direction of the physician in charge of the patient.

b. Boarding-out worker. The family-care or boarding-out department of a state hospital offers large opportunities to a certain type of acute patient and to certain chronic patients. When there are no relatives, no friends to offer homes to improved patients and patients who need community life in restoring them to normal living, good boarding homes are needed. A good boarding home also offers to a certain type of chronic mental patient normal home life outside institutional walls. For the past few years, because of the high cost of living, it has been almost impossible to enlarge the family-care departments of our state hospitals. The fact is that the sum allowed by the Department of Mental Diseases is not large enough to provide proper care and living conditions. The boarding-out department cannot grow until an adequate sum is allowed for the care of patients in the community.

The boarding-out visitor should study the patients recommended by the physician for the department, should investigate and visit the homes, and study the boarding mistresses so that she can place intelligently the patients in the homes where they will fit most contentedly. Numbers of patients who originally start community life again in the boarding-out department can later be discharged as self-supporting, happily adjusted individuals.

c. After-care workers. There should be at least two workers in a large state hospital to do real social case-work. Thorough investigations of the situations that led to commitment, careful planning with the families of patients, assisting the family through the crisis of commitment, tying them up with the proper agencies if they are in need of financial aid or medical attention, assisting with the care of children, educating all the members of the family, helping the neighbors, the relatives, and the friends to understand the illness, preparing the way for a speedy return to the community in every possible case, careful, intelligent supervision of the patient over a long period after he has returned to his home, are all necessary if we expect success in reëstablishing and readjusting our patients. What right have we to expect that the patient will continue well if we allow him to return to the same conditions that led to his break down, such as illness in other members of the family, deep financial worries, unsanitary home conditions, unfriendliness and misunderstanding?

d. Employment worker. During normal times, it is difficult to find employment for the handicapped. The physically handicapped stands a much better chance than the mentally handicapped, for his illness is at least partially understood. The world at large still fears the mentally ill, still does not understand and is skeptical about offering employment. A worker whose entire time could be given to studying the field of employment, studying the positions in her community that could be safely offered to mental patients, who could find employment and then carefully supervise for several months those who are employed, would undoubtedly prove an economic factor in the state. Besides the economic value to the state and to the community, the therapeutic value to the patients of such work cannot be emphasized too strongly.

e. Syphilis worker. Unquestionably there should be in every state hospital a social worker to handle the syphilis problem. All patients who are committed to state hospitals are examined for syphilis as a matter of routine, and in all cases possible, where the Wassermann test is found positive, examinations of the spinal fluid are made. I think I am correct in my statement that in no state hospital except the Psychopathic has any definite program been offered in the way of preventive work with the families of patients whose laboratory findings are positive. The Boston Psychopathic Hospital is the only hospital in the state that makes any attempt to deal with this serious problem.[1] The field has unlimited possibilities for preventive work.

f. Case-worker in the out-patient department. The need of social service in any out-patient clinic hardly needs mentioning. Here, again, is a field for preventive medicine. The psychiatrist's recommendations, his plans for care and treatment, can be carried out only with the assistance of a specially trained psychiatric social worker. The out-patient departments of all our state hospitals should be enlarged, should go forth into the community as have the out-patient departments in all general hospitals.

IV. *Clerical Assistance.*

The filing, record keeping, and routine office work in a fully equipped social-service department are no small part of the day's work. This part of the work must be done and must be kept up to date to be of real value to the physicians. An office manager to do the secretarial work of the chief, and at least one stenographer to do the record writing, filing, etc., are absolutely essential. With proper stenographic help, more attention could be given to the records. Good work can be demonstrated only by good records.

1 For literature on this subject see *The Family of the Neurosyphilitic*, by Harry C. Solomon and Maida H. Solomon. MENTAL HYGIENE, Vol. 2, pp. 71-80, January, 1918; *A Study of the Economic Status of Forty-one Paretic Patients and Their Families*, by Harry C. Solomon and Maida H. Solomon, MENTAL HYGIENE, Vol. 5, pp. 556-65, July, 1921; *Effects of Syphilis on the Families of Syphilitics Seen in the Late Stages*, by Harry C. Solomon and Maida H. Solomon, *Social Hygiene*, Vol. 6, pp. 469-87, October, 1920; *Social Work and Neurosyphilis*, by Maida H. Solomon, *Social Hygiene*, Vol. 6, pp. 93-104, January, 1920.

PSYCHIATRIC SOCIAL WORK IN A RED CROSS CHAPTER*

MARGARET WORCH

IN August of 1919, Dr. Douglas A. Thom, of The National Committee for Mental Hygiene, went to St. Paul, Minnesota, to look over the field in order to see what were the opportunities for psychiatric social work in the care of ex-service men. There had never been any psychiatric social work done in St. Paul, so that a worker coming there would have a great deal of pioneering to do. Dr. Thom decided, in conference with the executive secretary of the Red Cross Chapter and with the executive secretary of the United Charities, that there was an opening for such a worker. In order to cover as large a field as possible, it was decided that the worker should divide her time between the United Charities, caring for civilian cases, and the Red Cross, caring for ex-service men. Her first obligation, however, was to the ex-service men.

Accordingly, a worker, whose expenses were paid by The National Committee for Mental Hygiene under the Anderson Fund, was sent to St. Paul in January of 1920. She worked during half of the week in the free medical dispensary of the United Charities, acting as clinic manager in a new nervous and mental clinic and doing social case-work and follow-up work on selected cases among the patients coming to the clinic. The other half of the week she gave to the Red Cross. For the first three months, she gave three mornings a week to home investigations of mental and nervous cases among the returned service men, and two hours one afternoon a week to office interviews in the Red Cross office. The cases were referred to her by the other workers in the chapter, who sent her such cases as seemed to them to present psychiatric problems, and by the neuropsychiatrists in the Public Health Service, who were glad to have social investigations made on their more puzzling cases.

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In St. Paul, as in all large cities, the aim of the Home Service is to assist ex-service men, soldiers, sailors, and marines, and their families, in their problems of social maladjustment. In rural communities, the Home Service does not limit itself to ex-service men, but in cities and communities where there are social organizations already operating the work is confined strictly to men who have been in military service and have a disability resulting therefrom for which they are entitled to compensation from the government. Compensation includes a monthly cash pension, ranging from eight to a hundred and fifty-seven dollars, and free medical treatment, either in clinic or in hospital. Every man honorably discharged from the service with a disability traceable to service, or aggravated by service, is entitled to this medical care, which is given through the United States Public Health Service.[1]

When the care of these men receiving treatment from the Public Health Service became an acute problem, it was found that the Public Health Service was not in a position to offer them social as well as medical treatment. The Red Cross, therefore, offered to look after the social treatment of these cases through the Home Service Section. Thus all social work for ex-service men devolves upon the Home Service in each locality. The Home Service tries to reach not only the individuals who need financial aid, but also those who are not socially adapted to their community. "The job of the Home Service worker concerns itself frequently with personal social service to many who under no circumstances can be classed as having problems due to poverty, so the time may come when rich as well as poor will seek the services of the social interpreter, to assist in solving their family problems."[2]

Cases are referred to the Home Service Section of the local chapters differently in different cities. In St. Paul, the Home

[1] This work is now being done by the Veterans' Bureau, which was created by Act of Congress, August 9, 1921, to take over the functions of the Bureau of War Risk Insurance and the Rehabilitation Division of the Board of Vocational Education, and all the activities of the Public Health Service relating to ex-service men, with the exception of the conduct of such hospitals and dispensaries as are oporated by that service.

[2] Agnes L. Murray. *Case Work Above the Poverty Line.* Proceedings of the National Conference of Social Work, Kansas City, May, 1918.

Service receives a day sheet recording the names and addresses of all men who are examined at the Public Health Service clinic, and the name of the examining physician. If the man is not already known, a new case is at once opened, a complete medical report on the man's condition obtained from the Public Health Service, and a home investigation made within the month. All cases coming to our attention in this way were not immediately registered at the confidential exchange, since we felt that such registration would mean turning the exchange into a recording bureau for the men who received medical treatment from the Public Health Service. However, after the home investigation, the case was usually cleared through the exchange. If there was no registration already, and the case worker felt that there was no problem demanding attention, we made no registration. This arrangement applied to the psychiatric as well as to the general medical cases.

In October, 1920, the psychiatric social work in the chapter had so increased in volume that the Anderson Fund worker was allotted an untrained assistant, whose salary, however, was paid by the Red Cross Northern Division, not by the chapter. In November, the Anderson Fund worker found that it was necessary to give up her work in the United Charities Free Dispensary in order to devote her full time to the ex-service men. In January, 1921, about a year after psychiatric social work was first introduced into St. Paul, she resigned, and the chapter itself paid the salary of a full-time worker, giving her one of their regularly employed visitors as half-time assistant. These two workers handled on an average of one hundred cases a month.

A separate card index was kept for the nervous and mental patients. Each card contained a brief statement of all steps taken on the case, so that should it come up during the absence of the worker, any one in the office might tell what had been the last action taken. These cards were kept up to date, even if the record itself might be behind.[1]

[1] These cards were very helpful at first when the psychiatric social worker gave only half time to the Red Cross work. At present it is a question whether keeping them up does not take too much time, since there is usually a worker familiar with the case available in the office.

In addition to this index, all mental and nervous cases were "flagged" with green markers in the general file, so that no worker, in looking up a case unknown to her, would attempt to prescribe social treatment for a psychiatric patient without first consulting with the psychiatric social worker.

We made no distinction between long- and short-service cases. We tried to do what had to be done and a little bit more, but beyond this we could not go, because of pressure of work. Once a case was referred to the psychiatric social worker, she handled it in its entirety. She administered relief when it was necessary, and no relief was given to a psychiatric patient without her consent. If for any reason she thought such relief should be discontinued, her recommendation was practically always followed. She handled such matters as the drawing up of budgets when families were taken on for a long time, discussed ways of cutting down expenses, and so on. In addition, she gave the psychiatric patients informational service on government insurance, state bonus claims, and the like. I wish to stress this point particularly, as it is a departure from the practice in some offices, where the relief and financial sides of a case are handled by the family case-workers, and the technical sides of the government claims by a general informational worker. The practical arrangement whereby this was worked out meant that the psychiatric social worker gave the mornings to field work and the afternoons to office interviews. Our worker made no selection of the cases on which she wished to work. A few each month demanded concentrated treatment for a short time because of the nature of the problem involved. When a man had to be committed, it would sometimes take three or four days of work to arrange for the commitment, but once this was accomplished, the case became inactive for the time. When the doctor pronounced the man recovered, or when he died or left town permanently, we closed the case, but otherwise, once referred to the psychiatric social worker, it remained her problem and hers exclusively.

In order that we might see that no cases lapsed, we started a tickler file, setting the cases two months ahead from the date when last seen. This system had to be partially abandoned, however, because of pressure of work.

One of our initial difficulties was in obtaining diagnoses upon our cases. Very often a man would be referred by another worker in the chapter, who thought that he was "queer" or "nervous", and had found that he had had a psychiatric examination. In order to obtain the diagnosis, under the arrangements existing when the work first began, it was necessary to write to the liaison officer in the district supervisor's office, asking for the results of any psychiatric examinations that might have been made of this man. It took two weeks to receive an answer to this inquiry. Later, the psychiatric worker was given access to the files of the neuropsychiatrists, so that she could refer directly to them, without having to wait for a report of the diagnosis. This was of inestimable value in the social treatment of the cases. In February, 1921, a special arrangement was made with the chief of staff of the St. Paul clinic, whereby the psychiatric social worker received a carbon copy of all examinations and recommendations made upon the nervous and mental patients coming to the St. Paul clinic for treatment. The possession of these medical records expedited the work and automatically referred all cases not already known to the psychiatric social worker for her attention and for an investigation.

This was a great concession, and it was secured through the neuropsychiatrists in the Public Health Service. From the first, our relations with them were very encouraging and unusually close. We had free access to the records of the Public Health Service Mental and Nervous Clinic, as I have said, and free opportunity for conference with the psychiatrists in charge of the clinic. A course of treatment was usually mapped out by the psychiatrists in conference with the social worker, and difficult points were discussed before a decision was made. Usually these conferences occurred about once every ten days, but the psychiatrists were always available when an emergency arose. They made some sort of recommendation on practically all the patients coming to the clinic, for the worker to follow in her treatment. This coöperation was particularly helpful to the worker. No important steps were taken in the treatment of the mental and nervous patients among the ex-service men until the psychiatrists had first been consulted concerning their advisability.

When a patient was pronounced not compensable—that is, when it was decided by the Bureau of War Risk Insurance in Washington that the disability claimed was not a result of service[1]—we were obliged to turn the case over to a civilian organization, unless the man was anxious and able to reopen his case with affidavits, establishing the service connection of his disability. In turning over these cases to a civilian organization, we gave the essential facts, but not the diagnoses, since it is forbidden to give out diagnoses on any government patient. We described the condition of the patient in as simple language as possible, with no technical terms, at the end venturing a recommendation as to the best social treatment to pursue. The civilian organizations coöperated with us, and we were able to follow several of our patients through their reports, at least to a partial readjustment in the community. St. Paul has one mental and nervous clinic for the use of civilians; the physicians in charge of this clinic are the same as those in charge of the Public Health Service clinic. Thus the patient, when transferred to the civilian organization, is given the benefit of the same treatment as had been planned for him under the Public Health Service.

It is usually easy to hospitalize a man under the Public Health Service, but it is hard to have a man committed, since the Public Health Service does not commit any patient. All treatment received from the government is purely voluntary. Therefore, when a patient requires immediate hospital treatment and is unwilling to go to the hospital, or when the only Public Health Service hospital for the district is full, it is necessary for the patient to be committed through the local probate court and sent to a state hospital for the care of mental patients, where his expenses are paid by the government. From the state hospital he is often transferred to a Public Health Service hospital. Once in one of the Public Health Service hospitals for the care of mental patients, a man may

[1] The decision was based on the reports forwarded to the bureau by the local examining boards of the Public Health Service. Local examiners had not the power of deciding whether a case was or was not compensable. This has been changed by the passage of the Sweet Bill.

be restrained from leaving,[1] but there is no way of seeing that a man who is mentally ill and who refuses to go to a hospital will receive adequate care, unless he is committed directly to a civilian institution.

To facilitate these commitments, careful histories were taken on all cases, before the patient reached the psychiatrist. Although most of the nervous patients reached the psychiatrist before coming to the attention of the social worker, I believe that no psychotic patient reached the clinic without first coming to the attention of the social worker. The reason for this is obvious. Most of these men, if they were applying for treatment voluntarily, came into the Red Cross office in such an excited state that it was impossible not to detect their difficulty at once. In several cases, they were brought in by their relatives who demanded a "complete examination for insanity". The rest were referred to the psychiatric social worker by the Public Health Service itself, before they were referred to the psychiatrist.

When a man had to be committed to a civilian institution, we applied to the clerk of the probate court, to call in the Public Health Service psychiatrists as examining physicians. These psychiatrists had already examined the patient and had found him in need of commitment. The petition that the man be examined to determine his sanity was usually filed in the probate court by the relatives of the man. In a few cases, a private physician to whom the case was known filed the plea for a hearing.

Arrangements were made with the superintendent of the hospital to which the patients from St. Paul were sent, so that the social worker could keep in close touch with the men while in the hospital. Reports on the progress of the patients in the hospital were sent fairly often to the social worker, and she kept the hospital authorities in touch with the home situations, when these presented some special difficulty. She also sent full histories on all cases to the superintendent. When

[1] Legally this is not permissible, since the man is not committed to the hospital. Practically, many institutions hold mental patients on the grounds that they applied for treatment when sane, for a period of insanity through which they felt they might be going. Therefore, the hospital should hold them until they can apply for discharge as sane individuals.

the men were paroled, the Red Cross was notified, and through an agreement with the state board of control, the proper after care and supervision were given by the Red Cross social worker, without conflicting with the state parole agents, to whom the patient was technically paroled. Thus the patient was followed by the Red Cross psychiatric social worker, from the time of his first examination by the Public Health Service psychiatrist, through his commitment, while in the hospital, and again on his return to the community.

The paroled patients were kept in close touch with the physician. If any mental disturbance occurred, the state board of control was at once notified, and the patient returned to the hospital. When it was necessary, we gave the family of a patient in a hospital a weekly allowance to support them until the man's compensation came through. We found that when a patient was relieved from the worry and strain of supporting his family, he often improved rapidly in the hospital. No man was ever hindered from accepting hospital treatment recommended by the psychiatrist because he did not have enough money to support his family while he was in the hospital.

The Public Health Service asked for full psychiatric histories on all the psychotic patients, as a routine matter, and even suggested that we obtain full psychiatric histories on all cases referred to the psychiatrist. The plan was for us to see each man before the psychiatrist made his examination, and get from him his own account of his difficulties. This plan did not work out at all well. We found that many men concealed the true facts of the case, and many—in fact, the majority—of the nervous cases reached the physician before they reached the social worker, owing to some confusion in sorting out the nervous patients. Also, we could not afford the time necessary to take a long personal history on every patient. This would have meant that one worker did little else except take histories, when the number of new patients ran as high as twenty-five or thirty a month. A compromise was, therefore, arranged. We made full investigations on all mental patients, including interviews with relatives, explaining to them the necessity for hospital treatment, etc. On the nervous patients, we made a full home investigation and

talked with at least one disinterested informant. We attempted to find the origin of the trouble or the character trends of which it was the outcome. In addition, we tried to obtain a short personal history from the patient himself, to check with the information received from the outside source. This was done within a month from the time the case was first referred to us from the Public Health Service, through the carbon copy of the physician's report of his examination of the patient. In a great many cases, the investigation went no further than the home investigation and the interview with the patient himself; not because we felt that this was necessarily a sufficient investigation, but because, unless there were marked signs of social maladjustment, we had no time for further investigation. However, we did no intensive work without first having as full a social investigation to work upon as it was possible to obtain. In addition to this social information, we always had a full medical report on every case referred to us, which was obtained through the liaison staff at district headquarters, so that if a man needed care beyond that indicated by the diagnosis sheet received from the Mental and Nervous Clinic, we would be able to see that he got it, either by advising him to go to the Public Health Service to receive the treatment that had been recommended, or by conferring with the psychiatrist concerning this other physical condition and the best treatment for it in view of his mental or nervous condition.

The connection of the psychiatric social worker with the Federal Board for Vocational Education was never very satisfactory. Vocational training for the mentally disabled had never been tried to any great extent before the fall of 1920. The technique for handling these patients in conjunction with the chapter was never fully worked out. We tried sending histories to the board on these patients as a routine matter, but this was discontinued, as we felt that the educational value of the histories did not compensate for the real injury done to the men in labeling them "mental cases". That a history might be taken on a patient where the difficulty was slight or the disease mild was an idea very hard to get across. If a man's condition was bad enough to need three pages to explain it, it must be very bad indeed.

Our final solution was a compromise. We rigidly followed up the physician's recommendations on all the mental and nervous patients, either ourselves or through the board. This was easy to do, as we had the original diagnoses and recommendations on file in our own office. We held occasional conferences with the Federal Board executive, and gave a brief and informal history on each case as it was brought up for discussion, and with the executive tried to map out some form of treatment that would be helpful and constructive.

Owing to scarcity of employment, no effort was made this winter (1920-21) to try to establish relations with any of the large manufacturing concerns that might have been in a position to employ a man with a mental or nervous handicap. Temporary employment, which sometimes led to permanent work, was always obtainable through the employment bureau of the American Legion. We often referred men to this bureau, asking, for instance, that they be given work that would not require their climbing or bring them near machinery, in the case of epilepties, or that a man be given work out-of-doors, or on a farm, etc. The problem of employment for these patients while they are waiting for an award of vocational training is very great. There is no satisfactory way of meeting it at present, but signs point to the establishment of a bureau for the employment of the handicapped within a short time. Should the employment situation lighten, an attempt will be made to establish friendly relations with one of the big packing houses, either Swift's or Armour's, to secure employment through them. These houses offer a large variety of employment, and we have felt for some time that it would be possible to place patients with them, if the situation were carefully canvassed with the executives and the individual cases gone over with the foreman.

The St. Paul clinic takes care of a large number of men from the district (Montana, North and South Dakota, and Minnesota), as well as the men from St. Paul. A large number of these men became known to the St. Paul Red Cross while they were in St. Paul for treatment. There were also a great many men from the district who were receiving training from the Federal Board. When men of either of these

two classes returned to their homes, their names and addresses, together with a detailed report on their mental, physical, and social condition so far as known, were as a matter of routine referred to the neuropsychiatric liaison officer, who supervised, through correspondence, the after care of the nervous and mental patients when they had returned to their homes in the rural communities. In special cases, some of these men were kept under the supervision of the psychiatric social worker in the St. Paul office. If we had had any contact with the families of these men, or if we had had much contact with their local Home Service representative, we continued to supervise their care. This was done by letter, and in one or two cases, where the Home Service representative was coöperative, the results were good. We referred the case, with a complete history and recommendations, to the worker, outlining the treatment that seemed advisable and asking her to report back to us on the progress of the case. Most of the local representatives are untrained in the care and treatment of nervous and mental patients, but as a rule they are anxious to help, though frightened at the prospect of having to look out for a patient who is "queer". As the reports came back to our office, we suggested further steps in the treatment which we thought would be helpful, always explaining carefully our reason for these suggestions. The plan worked surprisingly well. Several of these patients were at least partially adjusted to their community environment; one was to be sent to Norway to rejoin his wife and little girl, and three or four, on reëxamination, after they had been under supervision in their homes, were pronounced by the psychiatrist to be showing no trace of nervous disorder.

There are possibly eight or nine chapters in this country doing psychiatric social work: Cleveland, Cincinnati, Louisville, Detroit, Chicago, New Haven, and several other cities, such as St. Louis, Boston, and New York, where the work has been done spasmodically or by comparatively untrained workers. In Detroit, the work has been carried out along much the same lines as in St. Paul. It was begun in January, 1920, but was temporarily discontinued in January, 1921. A psychiatric social worker was added to the

staff because the chapter decided that it needed a specially trained worker to do the follow-up work on the mental and nervous patients. The number of these patients was increasing month by month, and the chapter had no facilities for treating them. The cases were referred to the psychiatric social worker (1) when the man's discharge showed a mental disability, (2) when the family reported that his mental condition was abnormal, (3) through other agencies, etc. There was no way of being sure that all men coming to the psychiatrist were followed up by the social worker. Otherwise the work did not differ materially from that done in St. Paul. The Detroit chapter has never attempted to supervise cases by correspondence.

In Chicago, psychiatric social work was begun in March, 1921, at the request of the American Red Cross, Central Division. There are three workers, at present handling a total of 87 cases. The work was begun mainly to follow the patients discharged from the hospitals treating ex-service men in Chicago. Later, the department took over the supervision of men discharged from the state institutions and from the Psychopathic Hospital. Very little investigating as a preliminary to getting the man to the psychiatrist has been done so far. As a rule, the men are not referred to the psychiatric social worker until all preliminary investigations have been finished, a diagnosis arrived at, and recommendations made—i.e., the work is mainly after care. Patients are referred through the Red Cross officers in the district supervisor's office, or through the Central Division office, never directly from the psychiatrist. All contacts with the psychiatrist on behalf of the men under social treatment in the chapter are made through the district office. Contacts with the Federal Board are made through the division office, never directly. The psychiatric social worker handles the patient and any problem that affects his health. The regular family case-worker is responsible for the financial care and for the handling of the government claims. The psychiatric social worker spends most of her time in the field, and practically none in the office. Some correspondence work is done.

In Cleveland, the plan is entirely different. There is a

neuropsychiatric department in the chapter, with a psychiatrist in charge of the clinic, assisted by a psychologist and four psychiatric social workers. The clinic was established on the initiative of the chapter, in conjunction with the Home Service Section. The clinic is designed to serve ex-service men, members of their families, and cases referred by other social agencies. The cases are referred through the Home Service Section, and by them to the department. One worker handles the case exclusively, once it is referred to her, but a great deal of the preliminary social investigating is done through the Home Service Section visitors, rather than by the clinic staff. Men taking vocational training are under supervision from the department, and treatment for these cases is mapped out in conference with the Federal Board executive. There is also a considerable amount of hospital social service for the ex-service men done through the clinic, the visitor who does this work being ranked as a part of the hospital force in investigating and reporting home conditions. Little work is done in supervising cases by correspondence.

All of these three chapters just mentioned have been able to refer their cases needing employment to various bureaus for the employment of the handicapped, but none of them has any satisfactory solution of the employment problem. Cleveland is looking forward to establishing a workshop which will serve as a therapeutic measure and will enable a man to take his place in the working world on a low level, when asking him to take a place in normal industrial life would be too severe a demand.

Detroit, like St. Paul, has only a small department. Here the great defect seems to be that all cases are not referred to the psychiatric social worker for investigation. In Chicago, it would seem that lack of direct contact with the psychiatrist, both in sending in data and in receiving recommendations, must be a severe handicap to the work. The work in Cleveland is on such an entirely different basis from that of the other two chapters and from that done in St. Paul that comparison is difficult. The system in itself seems quite ideal, but since the clinic is not under the Public Health Service, it would appear that there might be complications in the

adjustment of claims. However, the plan must certainly make for speed and efficiency, both in diagnosis and in treatment.

Psychiatric social work in a Red Cross chapter occupies the same relation to the care of the ex-service man that psychiatric social work in a charity organization society does to the care of the civilian. Just as the efficiency of agencies dealing with special problems is apt to depend in the last analysis upon the efficiency of the general family-welfare agency, so the efficiency of the Red Cross worker, directing after care by letter or working in a Public Health Service hospital, depends on the work done in the chapter. In the chapter, we get family-welfare problems, desertion, unemployment, and so on. We act as a clearing house, referring special types of problems to specialized branches of the Red Cross, after we have done the preliminary investigating, exactly as the Charities refer unmarried-mother cases, children's problems, and the like, to the agencies equipped to handle these particular problems. When the special problem is solved, the case is referred back again to the general agency, in one case to the Charities, in the other to the chapter. Most cases of disabled ex-service men begin and end in the chapter.

In June, 1921, a year and a half after psychiatric social work had been introduced into the St. Paul chapter, we attempted a survey of the work that had been done. We compared the number of psychiatric patients handled per month with the number of general medical patients handled per month, to see what was the proportion of psychiatric patients to general medical patients. We made the comparison reckoning from November, 1920, since at this time the psychiatric social worker first began doing full-time work with the Red Cross. The following table shows the number of general medical cases, the number of psychiatric cases, and the total of both handled each month from November until June. It also gives the proportion of psychiatric cases handled each month to the total number of cases on which case-work was done. We have not included the number of cases on which only informational service was given. We kept no record of psychiatric cases on which the work was only informational, but we believe that the number of these was negligible.

Cases Handled from November, 1920 to June, 1921

Month	Total	General Medical Cases	Psychiatric Cases	
			Number	Per cent
November, 1920.	902	751	151	16.7
December, 1920.	891	774	117	13.1
January, 1921.	954	853	101	10.6
February, 1921.	963	856	107	11.1
March, 1921.	974	872	102	10.5
April, 1921.	1,008	888	120	11.9
May, 1921.	860	731	129	15.0
June, 1921.	824	704	120	14.6

Next we compared the work done in the psychiatric department from month to month over the period from February, 1920, to June, 1921. We found that the number of new cases per month averaged around twenty, with the exception of the months of August, September, and October, 1920, when the psychiatric social worker was away a great part of the time. The number of cases handled per month jumped from two in March to one hundred and forty-three in October—proof that psychiatric social work for the ex-service men was needed and its value appreciated. From January, 1921, to June, 1921—that is, since the chapter has employed its own full-time worker—the total number of cases handled each month averaged about one hundred and ten. We also compared the number of visits each month with the number of office interviews, and found that in those months when the office interviews ran high, the number of visits dropped and vice versa. This meant that we had managed to strike a balance between the two, and we believe it was our flexible methods of handling the work that enabled us to do this.

We had never classified our social data by diagnoses, since similarity of disease does not presuppose similarity of treatment, but we were able to draw up a table showing the frequency with which the various diagnoses appeared. This table is interesting, as it shows the preponderance of the diagnoses of neurasthenia and dementia praecox. During the war a large proportion of the mental and nervous disorders among the soldiers, both in the British and the American forces, were given one or the other of these two diagnoses.

Diagnoses of 398 Cases of Mental and Nervous Disorder, Referred to the Psychiatric Social Worker from February, 1920 to July, 1921

Diagnosis	Number
Syphilitic conditions	35
Epilepsy	31
Nervous condition secondary to cerebro-spinal meningitis	7
Nervous condition secondary to encephalitis lethargica	4
Psychosis due to drugs	4
Constitutional psychopathic inferiority with psychosis	6
Neurasthenia	123
Functional neurosis	9
Anxiety neurosis	2
Hysteria	4
Psychoneurosis	6
Manic-depressive psychosis	5
Dementia praecox	88
Alcoholic psychosis	2
Melancholia	3
Neurologically negative	34
Unascertained	23
Mental deficiency	9
Mental deficiency with psychosis	3
Total	398

The success of our work was first attested when the chapter employed a worker at its own expense to take over the care of the mental and nervous cases, when the Anderson Fund worker resigned, and, in addition to this, detailed one of its regular staff to assist in the visits as well as in some of the office interviews. This meant that the work was not only established, but an essential part of the organization, so that the executives of the chapter felt that it must continue, even though this meant considerable expense to the chapter. Using an untrained assistant worked out well, and the chapter will probably continue to detail one visitor to handle mental and nervous patients under supervision.

The work in the chapter is psychiatric social work plus all the contacts that it is necessary to make for the government patient with the Public Health Service and with the Federal Board for Vocational Education.[1] This is only a form of coöperation with other agencies already in the field, but it is such a specialized coöperation that it deserves separate mention. In the field of government contacts, we are beginning to

[1] See note 1, page 313.

see results. Several claims that had been pending for a long time were settled by submitting long, careful histories to the Bureau of War Risk Insurance through the district supervisor's office. One claim had been pending for almost three years and had been disallowed twice, but was very satisfactorily adjusted after the history was sent in with a report of the last examination. A history, backed by affidavits to establish its truth, is a convincing piece of evidence, but it takes time and patience to get this proof, and it is not always possible to get it.

We obtained the interest and coöperation of the Public Health Service in asking for histories on all the mental cases, and in giving thorough and frequent medical treatment to some of the cases on which we were doing our most intensive social work. We were practically always able to secure a psychiatric examination for men whom we suspected of having a nervous or mental disease. Many men who would otherwise not have come to the attention of the psychiatrist were brought to him, through the general clinic, by the psychiatric social worker, who came in contact with them when they filed their claims, or as she went about in the community and heard of them from their families or friends.

We were not successful in our contacts with the Federal Board. This was partly due to the newness of the idea that the mentally handicapped could benefit by training, and partly to the fact that the Federal Board was undergoing considerable reorganization during this last spring. If it were possible for the psychiatrist and the Federal Board executive to have direct contacts, as in some cities, much could be accomplished in a short time that takes a long time when the social worker has to act as middleman between the Federal Board and the psychiatrist. One whole process could be cut out by direct contact between physician and executive. However, without the social worker to act as intermediary, many of the cases would not have received the medical treatment that they sorely needed, and to which they were entitled.

In addition to connecting the ex-service man with the Bureau of War Risk Insurance, the Public Health Service, and the Federal Board for Vocational Education, which is a function of any social worker handling the case of a compensable

ex-service man, the psychiatric social worker has also the following functions which are peculiarly her own:

I. To facilitate admission to hospital or clinic and continuance of treatment.

II. To bring to the physician personal and social data helpful in arriving at a diagnosis and in outlining treatment.

We combined these two functions by seeing that histories on as many mental and nervous cases as possible were sent to the psychiatrist through the general clinic. That we could is due to the organization of the Public Health Service, where every man must first be referred to the general medical clinic before being referred to a specialist. Many of our patients had already been through the general medical clinic and had been reported there as "organically sound, able to resume former occupation".[1] Later, they came into the Red Cross applying for relief, because they were "too nervous" to work. Such cases were referred to the psychiatric social worker, who took a history and referred the patient back to the general medical clinic, with the history. Certainly we expedited the referring of many men to the proper clinic, and through the histories aided both the psychiatrist and the general practitioner in mapping out treatment for them.

III. To assist in carrying out treatment.

Where we failed in the social treatment, the failure was primarily due to pressure of work. We had the facilities at hand, in the way of clinic and hospital, and we had means of following up the cases to see that they received the treatment recommended, but we often did not have the time to do it. This is righting itself, however, as the work gradually becomes better established and results are attainable with less effort. The unusually close contacts that we established with the psychiatrists gave us the chance to assist in carrying out the treatment that they recommended. When the psychiatric social worker first began, she voluntarily did much social work, before the psychiatrists asked for it. At present, the

[1] That so many of the men did slip through the general clinic is no criticism of the clinic staff, since the large majority of the patients gave the examining physician no account of their symptoms. They presented themselves silently for a physical examination, thinking that compensation would be automatically awarded to them. When asked how they felt, many answered, "All right."

psychiatrists expect their routine recommendations to be followed up and are constantly expecting more and more work to be done. What we offered to do at first, or did voluntarily, is now expected of us as a matter of course, and more besides.

IV. To interpret hospital and clinic to patient, family, and organizations of the community.

This, being an educational job, was one of the biggest among those that faced the psychiatric social worker. With the patients we adopted an attitude of perfect frankness. We could not run the risk of their believing that we had tried to hide from them that they were being referred to a "mental" clinic. Our belief that this was the best way to interpret the clinic, and to get the patient in to see the doctor and later to accept hospitalization, was justified. Out of 398 cases, covering a year and a half, we failed only twice to get the patient to the clinic; one of these patients was committed almost immediately by the civil authorities, and the other was declared committable by the physician when he visited the patient at his home. Both were described by the examining physician as "highly resistive and antagonistic". We used the same attitude toward the family, and in many cases induced them to see that the patient was regular in reporting to the physician. In dealing with the other organizations in the community, we had some difficulty. The work was new, its aims were not clearly understood, and the other social agencies were wary in accepting it. But by "cultivating common sense"[1] we showed that the work was neither occult nor mysterious, and practically always won our point when we were trying to map out treatment for a patient with another agency.

It seems as if in a very short time there will be considerable public education done along the lines of mental hygiene. A mental-hygiene committee has been formed, since the first psychiatric social worker went to Minnesota in 1920, in both Minneapolis and St. Paul, looking toward the formation of a state society for mental hygiene. The aim of both of these committees is the education of the public in the problems of

[1] See *The Minimum of Medical Insight Required by Social Workers with Delinquents*, by C. Macfie Campbell. MENTAL HYGIENE, Vol. 4, July, 1920. p. 520.

mental and nervous diseases, and a joint discussion of difficult mental or nervous patients. The committees are formed, in each case, of the executives of the leading agencies in the city. The committees meet every two weeks as a rule. In addition, there will probably be a psychopathic hospital built in a few years, which will form a center for educational work.

V. To make social investigations contributing to medico-social research.

We have done nothing along this line.

To summarize briefly, a year and a half ago psychiatric social work was started in the St. Paul Chapter of the Red Cross, by a half-time worker whose expenses were paid by an outside agency. At present, it is being carried on by two full-time workers, employed by the chapter itself. It has developed rapidly, proving itself of definite value in straightening out government claims and facilitating medical and social treatment of mental and nervous patients among discharged ex-service men. The period of pioneer work is past, and the period of development and expansion has begun. It is too soon to say, but we believe that the work is firmly established on a good working basis, which allows for growth and added usefulness.

ONE HUNDRED INSTITUTIONALLY TRAINED MALE DEFECTIVES IN THE COMMUNITY UNDER SUPERVISION

MABEL A. MATTHEWS

Head Social Worker, Massachusetts School for the Feebleminded

THE subjects of this investigation were not a selected group; they were studied because they were within easy reach of the school, and, not having been discharged, were still under its control. They had been allowed to return to their homes either because their parents or friends had asked that they might go "on trial", or because they had been taken home on vacations and, securing work, had for that reason been put "on trial". Two of these boys had "run away" from the school and had later been allowed to go on the list to report. Seven had been allowed to go out and take positions because it was thought that they were sufficiently trained to be self-supporting.

At the present time ninety-seven of the one hundred boys are living in the community. The school, by means of its follow-up system, has kept in touch with them. Some of them have excellent homes and require little supervision, but others, less fortunate, require constant oversight. Nevertheless, all are required to report at the school at regular intervals.

The group of seven referred to above, who are alone in the world, have been placed at work and are rooming in respectable lodgings. All except one of these seven have made friends and are pleasantly situated, but the seventh has not been so fortunate. He went out four years ago, before supervision began, and fell into the hands of unscrupulous people, who, although they did not lead him into any actual wrongdoing, fleeced him of all his earnings. When he was located, he was placed in a different environment and is now doing well.

Three of the one hundred boys have been returned to the school: one for committing an indecent assault, another because he either could not or would not keep a job and his

people wished his return, and the third—a young boy whose training is not yet completed, and who lost his job during the recent business depression—because his people wished him to have further training.

Of the extra-institutional cases still in the community, five are young boys with a fairly high I. Q. who are living at home and attending the public schools. Two other boys with a mentality of less than eight years are doing farm work at home. One boy, twenty-four years old, has a mental age of less than eight, and in addition is hemiplegic. He is unable to hold a position; he is, however, able to be of much assistance in housework at home. Another boy has a six-year-old mind and can do little that is of economic value, although he is of some assistance to his people. Two boys are in the army, one in the navy, and another is taking the government vocational-training work. Four boys are out of work because of the hard times. These four are living at home and are closely supervised by their people. Two boys have been sent to reform schools. Notwithstanding the present scarcity of work, and the fact that a number have had to find new jobs, seventy-eight boys are working and are self-supporting, although many of them have been reduced in pay or have had to take inferior positions.

An investigation of the conditions that led to the commitment of these boys showed that forty-five were admitted to the school through the courts for misdemeanors of a more or less serious nature, or because their antisocial traits and acts had so disturbed their relatives that they felt something must be done. Perhaps the most serious case was that of a boy with a nine-year-old mind who got into bad company and, following the example of his associates, who were older, drank heavily. One night, in trying to get money out of a gas meter in order to buy more liquor, he broke the pipes and gas escaped, killing his crony, who was lying in a drunken stupor. This was so serious an offense that only after much deliberation did the courts decide to consider the boy not responsible for the act and to send him to the school, where he remained a long time. His drinking had been due to the example of his low associates rather than to any strong desire for liquor. While at the school this habit sank into the background, and

he established habits of quiet, orderly living and industry. About three years ago he was allowed to go home "on trial". His people now understand the situation and are giving him excellent supervision. He works steadily and earns thirty dollars a week, which he gives to his mother. He is not spending his evenings on the streets and so has not drifted back to his old habits and acquaintances. He goes out with his brother to the "movies" or theaters, and is faithful in his attendance at church.

Twenty-five of the hundred were admitted to the school because their parents wanted them to have the advantages of the training at the school; twenty were admitted through the efforts of social agencies working throughout the state; and ten came through the efforts of hospitals or doctors. The boys entered the institution at various ages, but most of them were brought when they were young, eight or nine years old, stayed until they had passed the adolescent period of unrest, and went out at nineteen years of age or more.

The range of wages for the group under eight years mentally runs from $8.00 to $26.00 per week. There is no outstanding peak of wages for this group. One boy is a helper on a freight truck at $26.00 a week. Three are earning $24.00 a week—two as helpers on a truck and one as a roofer's helper. One has been getting $22.00 a week in a manufacturing plant, but he has within the last few days joined the navy. One is earning $20.00 a week learning the upholstering trade; three are getting the equivalent of $20.00 a week, one as a helper in a restaurant and two as farm hands. Two work on milk wagons and one on a peddler's wagon for $8.00 a week. The others are helpers either in factories or on farms.

The range of wages for those with eight-year-old minds is from $10.00 to $28.00 a week, the latter wage being earned by a boy who is a fire tender in a roundhouse. One receives $24.00 a week taking boards from a saw in a lumber yard. Of those earning $20.00 a week, one repairs automobile radiators and one nails boxes in a chocolate factory. In the $18.00 a week group, one is a boiler maker's helper, one repairs furniture, and two help on machines. One earns $16.00 as a stitcher in a tailor shop. Four others do rough work in factories and receive from $10.00 to $16.00 a week. Two are farm

hands receiving $20.00 a month and board; one works in a stable for $10.00 a week; one gets $14.00 as an errand boy; and one sets up pins in a bowling alley for $10.00 a week.

The range of wages for those with nine-year-old minds is from $12.00 to $30.00 a week. Of the two getting $30.00 a week, one is a painter and the other a machinist's helper. One packs glass at $28.00 a week, and one is an elevator boy at $18.00 a week. The others work either in factories or on farms.

The range of wages for those with ten-year-old minds is from $10.00 to $32.00 a week. One is an employee on the railroad at approximately $32.00 a week. In this group are those who drive teams and trucks. One is an errand boy in a bank, one works in a private office, and one is a canvasser.

Of those over ten years old mentally, the range of wages is from $10.00 to $34.00 a week. One is "directing stock" in a factory and has seven men working under him. This boy's history is interesting. Before entering the school he was a sex offender. When he was seventeen years old, he was allowed to go out, although against advice, but soon had to be returned to the school for the same offense. While at the school the second time, he was a leader among the boys and seemed to get better control of himself. He went out again when between twenty-two and twenty-three years of age, and went into a manufacturing plant as a helper. At that time he exhibited a great deal of ambition, wanting to accomplish something in the line of earning money. He also wanted to be respected and looked up to by other people. While he was a helper in the shop, he attended night school and in every way tried to emulate his older brother, who was attending one of the colleges. He was always pleasant and courteous in his manner and made friends easily. He was gradually promoted until, during the peak of high wages, he earned from $42.00 to $45.00 a week on piece work. When the business depression came and men were discharged, he was put in charge of a certain simple part of the work with seven men under his direction. His pay, however, was reduced to $30.00, which he is now receiving.

In this same group of over ten years mentally there is a truck driver at $30.00 a week and a painter at $26.00. One

boy is turning eggs in a hatchery; one who is nearly blind is a broom maker. A sixteen-year-old boy is making $10.00 a week as an errand boy. Several boys in this group are doing factory work.

It is noticeable that with the increase in the mental age, the wage earned by the greatest number increases—that is, of those with eight-year minds the greatest number are earning $18.00 a week; of those with nine-year minds the greatest number are earning $20.00 a week; of those with ten-year minds the greatest number are earning $24.00 a week; and of those with a mentality of over ten years the greatest number are earning $26.00 a week.

The minimum wage in each group was found to be as follows:

Those with less than an eight-year mind earn a minimum of....	$8.00
Those with an eight-year mind earn a minimum of.....	10.00
Those with a nine-year mind earn a minimum of.....	12.00
Those with a ten-year mind earn a minimum of.....	10.00
Those with over a ten-year mind earn a minimum of.....	10.00

The drop to a minimum of $10.00 a week in the groups of ten years and over ten years mentally is probably due to the fact that in these groups are boys who are chronologically younger and who therefore do boys' work.

With regard to the maximum wage, the findings were as follows:

Those under eight years mentally receive a maximum of.....	$26.00
Those eight years mentally receive a maximum of.....	28.00
Those nine years mentally receive a maximum of.....	30.00
Those ten years mentally receive a maximum of.....	32.00
Those over ten years mentally receive a maximum of.....	34.00

The fact that in the group of less than eight years of age mentally there are as many earning $24.00 a week as there are earning $8.00 may be due to the fact that those earning $24.00 a week are hod carriers, roofers' helpers, or workers doing similarly hard or dangerous work, and are, therefore, paid more. These same scales have since been worked out with twice this number of boys and show practically the same results.

The range of the kinds of work is as wide and as varied as the range of wages. Of course, the younger boys, chronologi-

cally—from fifteen to seventeen years old—are doing young boys' work; that is, they are messenger boys, office boys, errand boys, bundle boys, helpers in shops, etc. Some of these younger boys have ten- or eleven-year-old minds. In the right environment and under the proper supervision, they may become good workmen, and may earn as much as the older boys of the same mental age.

It is interesting to watch the progress of these younger boys. When they first go out, at about fifteen years of age, they get the least important parts of the work and earn from $6.00 to $10.00 a week. By the time they are seventeen years old, they are earning from $12.00 to $15.00 a week. They often succeed in the same place in which they begin, their faithfulness bringing them promotion. The young tailor is an interesting example of this. At fifteen years of age, with an I. Q. of 75, he went to work in a tailor shop as an errand boy, starting at $4.50 a week. At the end of a year, his pay being increased gradually, he was earning $10.00 a week as a "bushler". Later he learned to press at $12.00 a week, and in a few months was a presser at $14.00 a week. Now, at seventeen years of age, he is learning the stitcher's part of the trade and is earning $16.00 a week.

Probably the largest group of boys at work is made up of laborers and helpers in factories. They can run simple machines and do automatic work that does not require much intelligence. During this last winter a boy with a mental age of six years and ten months worked as a laborer for a contractor, earning $29.76 a week. Much of the time he mixed lime and carried a hod. In a family with a number of normal children he was the only member working and his money supported the family. This boy came to the school, at the age of twelve years, a quick-tempered, excitable imbecile; he went out at the age of eighteen years quiet, obedient, and with some degree of self-control. While at Waverley he received very careful training in the only kind of work that his mentality enabled him to do and went directly from the school to his job.

Another fair-sized group is successful at farm work. They are willing, faithful plodders, and though they may not like to get up early in the morning, they do not, as a rule, think of

objecting, but take it as matter of course. A number of boys are helpers on trucks and teams, while one or two do the actual driving. Milk wagons also furnish a place for one or two of them. There is also such work as lifting boxes, pushing trucks, sweeping floors, etc., for which industry can use the trained feebleminded. Many of the boys are doing work that they were trained to do while at Waverley; for example, some of them are employed as helpers in the kitchens of restaurants and lunch rooms, others are helpers in storerooms, and still others are painters.

That these boys are a success is due to the fact that they are faithful, conscientious, methodical, unquestioning workers. While at Waverley they were trained to work steadily and faithfully and to take pride in their work. They are painstaking with uninteresting details of their work, and it matters not how simple it may be, they take pride in doing it well. True, this pride needs to be stimulated by the interest shown by some one in authority. With this interest and a bit of praise, the boys take pride in digging a ditch with smooth, even sides, or in packing bricks into a hod firmly and evenly. They will do the same thing in just the same way day after day, and they will work until the bell rings. They seem to enjoy the monotony instead of tiring of the repetition. As a rule they will take a direction—if they understand it—and will follow it without questioning or stopping to debate whether it is really their job or whether it belongs to some one else to do. They do what is expected of them. They will be there at 7 a. m. and will not stop to reason whether eight o'clock would be better. If they are expected to work overtime an hour, they will do so, and if questioned as to how they like to work long hours, they usually reply, "I don't like to, but you know the boss wants to get this job done, and he can't if we don't work for him, and anyway he gives me some extra money for working overtime." If they can only be made to feel that they are expected to do a certain thing, there is something compelling about this feeling, and they do the expected thing.

Another great reason for their success is that these boys crave respectability. It is almost pitiable to see how they long to be looked upon as other men are, and to be thought of as

"somebody". Many of them come from poor homes—homes that have been supported by charity and visited by the police. Before coming to the school, they have felt the sting of scorn because they were slow in school and at play. They were ignored and therefore practically ostracized because they could not "keep up". The joy and satisfaction they show at having any one notice and praise them, either upon their appearance and conduct or upon their savings or work, is strong evidence that the love of approbation is a great factor in their success. Now that they have what they call a "chance", they exert every effort to suppress their unfortunate traits and habits, as they had been trained to do while at Waverley. They try not to let their fellow workmen know that they have been at the school or that there is anything going on that they do not understand. Some of the more intelligent ones get the reputation of being reserved because of their quiet withdrawal when the subject of discussion is beyond their comprehension. They try so hard to be and to act like their fellow workmen that with constant encouragement they succeed fairly well.

While at the school, they were taught the desirability of cleanliness. The officials of the school become their ideals of respectability and they want to be as well dressed and as well thought of as these officers. It is no uncommon thing to have a boy, when he first goes out, write at the end of the first month and say that he cannot report that first Sunday because clothing is so high that he hasn't been able to get all that he wants, and if he must come, can't he come early Sunday morning or on Saturday afternoon, when there will be no other boys there? Unless it is a boy about whom there is some uncertainty, he is allowed to wait until the second month to make his first report, for we have grown to realize how much this first report and the new clothes mean to him. Of course, the boys leave the school neatly and sufficiently well clothed, but this first new outfit seems to be an expression of their longing to be like others and to be respected. They almost never get clothing that is flashy. Either their native taste is good or else, in buying clothing, they get things that are as nearly as possible like those worn by people who have been their ideals.

While at Waverley, they are taught to save. They hear of bank books and look upon the possession of one as a sort of open sesame to higher levels of society. Therefore, following closely the new clothes, comes the bank book, and they are fairly steady savers—with encouragement. One often wonders if they actually appreciate the value of money. It is something that they have never had much of and for which they have little use. Now, all at once, they are getting what to them is a large amount. After they get the new outfit and their board is paid, they find that they have some on hand. They put this remainder in the bank because "respectable" people do and because they are advised to do so by the school. Few of them have any real idea of the necessity of saving. In fact, it does not seem as if one of them realizes that this money will be of great help to him in a time of need.

Few of them want, or expect, excitement. They are satisfied with the "movies" once or twice a week, and an occasional visit to the theater. Seven of them attend dances, but not one of them takes a young lady with him. They have selected reputable places and leave at a fair hour. Many of these boys are still interested in baseball, gymnasium work, and other athletics of various kinds. Most of them play on some neighborhood ball team. Swimming also is a source of great enjoyment to them. Many of them are interested in their church, and are faithful in attendance. Small groups of them go for long walks on Sunday, while many of them enjoy walking up and down the streets looking into the shop windows, especially clothing-store windows. Some of them have bicycles and get real enjoyment from them. On the whole, their evenings are short, and most of them are spent at home with a Victrola or games, or with books and papers, usually closing about nine o'clock.

The following stories of two boys will show what is meant by some of the traits mentioned above.

Tom is an illegitimate child who has no relatives and knows nothing of his ancestry. He was committed to the State Board of Charities in 1901, and came to Waverley in 1914, being committed to the school by the Overseers of the Poor. He had done no real harm, but had been unable to fit into any of their

boarding homes. The only question of misconduct at that time was drinking. While at Waverley, he exhibited few bad traits. He was friendly, quiet in his manner, fond of outdoor games, of military drill, and the like, but did not enjoy reading. He was fond of clothing, and, when opportunity offered, would appropriate articles belonging to other boys. In July of 1918, he went out "on trial". At first he went to work as a teamster, earning $3.00 a day. He soon took up the habit of smoking and chewing, but did not again use liquor. At the end of a year and a half he was earning $20.00 a week and had saved $205.00, some of which was in Liberty Bonds. In April, 1920, when he reported, he was earning $21.00 a week. He had been ill for two months and had spent all but $25.00 of his savings. Up to this time, he had saved as most of the others do, simply because it was thought to be the correct thing to do. Now he shows a keen interest in his bank book and is proud of the fact that he was able to be self-supporting during his illness.

Billy was born in 1896. He was admitted to the school in 1905 and went "on trial" in 1915. He has a mentality of 9-4. He came with a history of insanity in his family. At first he was sly, dirty, and apt to take anything that he thought he wanted. He was saucy and disobedient and was always trying to do something different from other people. He exhibited bad sex habits and was untruthful and selfish. Bill was in the school for eleven years, during which time he overcame these undesirable traits to a great measure. He became a slow, plodding boy, and although he instinctively felt the same inclinations, he at the same time recognized the undesirability of allowing himself to exercise them. He went out "on trial" to live with his mother and grandfather. He spent his evenings at home, and according to latest accounts, had beaten his grandfather 10,005 times at checkers, while his grandfather had beaten him only 3,025 times. His having played so many games of checkers in four years may account for his keeping out of trouble. Upon leaving the school, he went to work in a factory at $9.00 a week. Later in the same year, he went to work for one of the meat-packing places at $12.00 a week and began to save at the rate of $1.00 a week.

Perhaps all the credit does not belong to Billy, as he turns most of his money over to his mother and she superintends the saving.

Of the one hundred boys of this study only three have been arrested. One was returned to the school, and the other two were sent to reform schools. With the exception of the one boy returned to Waverley, none of these boys has done anything of an immoral nature. All but two of the adults in this group have been self-supporting and most of them have helped in the support of their families. It is noticeable that after a boy's training has made him an asset to his family, his people become interested in him and coöperate in his supervision.

The school does not handle the boys' money in any way, though it does advise, and to some extent direct, in the matter of the use of their money. Neither does the school deal directly with the employers. In only four cases, where the boys had no people, were the arrangements made for them. On the whole, it seems to work out better to allow the boy, or his family, to make the contacts and obtain the position.

These one hundred boys have been living in the community for from ten months to five years. Most of them have been out of the school between two and three years. At present, when the pressure for admission of young, teachable boys is so great, this community supervision for older, trained boys makes it possible to admit those who so much need this training and who otherwise might become delinquents.

This brief study shows that, with few exceptions, these boys have made good. Their success seems to be due to the painstaking, constructive training received while at the school and to proper supervision after going out into the community. We feel that, with continued friendly, helpful supervision, free from humiliating circumstances, the average feebleminded boy, properly brought up and trained to work, can live in the community and play his part there.

THREE HUNDRED PSYCHIATRIC EXAMINATIONS MADE AT THE WOMEN'S DAY COURT, NEW YORK CITY

AUGUSTA SCOTT, M.D.

Psychiatrist, New York Probation and Protective Association

IN the fall of 1920, the New York Probation and Protective Association, an organization that is intensely interested in the welfare of the girls and young women of New York, offered the part-time services of a psychiatrist to the Women's Day Court. It was not the purpose of the organization to undertake a survey or to carry out a statistical investigation. The idea was simply to gain an impression of the psychiatric material that presented itself in the court cases, to see whether a psychiatrist could be of service in helping the court and in aiding the probation officers in the handling of special problem cases. It was also the hope of the organization that the examiner would be able to help the individual girls to arrive at a better understanding of themselves and their difficulties. The work was begun on October 17, 1920, and was carried on until August 15, 1921; during these ten months 300 women were examined.

On account of the variety of the material, it was difficult to find a way to group and handle the records. For the purpose of discussion, the simplest plan seemed to be to classify the cases according to the nature of the charges made against the women, but doing away with technical terms.

The following table gives the groups with the disposition made at the time of examination:

Charge	Total	Dismissed	Placed on Probation	Sent to Institutions
Incorrigible	114	9	49	56
Prostitution	160	..	47	113
Disorderly conduct	6	1	1	4
Vagrants	6	2	2	2
Larceny	2	..	..	2
No formal charge	12	..	..	12
Total	300	12	99	189

Under the heading *prostitution* are included those arrested for committing or offering to commit prostitution; also those arrested for soliciting or violating the Tenement House Law. These, with the group of incorrigible girls, make up the mass of the material—that is, 274 of the 300 cases. The other groups will be disposed of briefly. Those termed *disorderly-conduct* cases and *vagrants* are not prostitution cases. Excepting one larceny case, the women came from other courts, but were held in the Jefferson Market Prison, and the examinations were made at the request of the probation officer who conducted the investigation. Of the six disorderly-conduct cases, two were insane and one was a chronic alcoholic. Two of the vagrants were insane. One of the larceny cases was seen at the request of the magistrate because her behavior was abnormal. She was found to be insane. The other larceny case was seen at the Tombs at the request of a probation officer from the court of general sessions.

The twelve women against whom no formal charge was made were referred cases. Two of them were witnesses; two were girls suffering from venereal disease who were brought by policewomen; two were referred by the probation bureau; five came from the Florence Crittenton Home; and one was a young woman sent from the Domestic Relations Court, where she had made a charge of non-support against her husband.

Of the cases sent to institutions, 104 were sent to the Kingston Avenue Hospital for the treatment of venereal disease. Sixty-six of them were prostitution cases. Thirty-six women were sent to the House of the Good Shepherd, nineteen to the workhouse, five to the New York State Reformatory at Bedford, eighteen to the Psychopathic Ward of Bellevue Hospital, two to the House of Mercy, and five to various institutional homes. In all, 138 of the 300 women had gonorrhea or syphilis or both, for many of those sent to the House of the Good Shepherd, to the workhouse, and to Bedford Reformatory were diseased. Fifty-five per cent of the prostitute group were diseased and 36.8 per cent of the incorrigibles had been infected.

The questions most frequently asked when one is discussing the work are: "How many of the girls are normal?" and,

"How many feebleminded do you find?" These questions are not so easy to answer, though it seems that one should be able to reply concisely with a few figures and percentages. The first question, as to how many of the girls are normal, will be taken up later in a discussion of a group of those who are normal in intelligence, but who present most difficult conduct problems. By the inquiry, "How many are feebleminded?" the questioner usually means how many should be sent to institutions for mental defectives. The lay person does not realize that institutions cannot possibly care for the great number of feebleminded or that many of the high-grade defectives can get along perfectly well in community life. With our institutions full, it is a matter of considering each individual case, seeking commitment only for those in the greatest need of protection—protection for themselves and protection for society against the spread of venereal disease and the reproduction of their kind—and seeking a suitable environment for the others. This means a study of the girl's sex proclivities, habits of industry, personality traits, and capacity for adapting herself to others. For example, one feebleminded girl was quite a good worker and fond of children, but she was subject to uncontrollable fits of temper, at which times she was actually dangerous; she was, therefore, committed.

The Intelligence Tests

It was not possible to give all the women intelligence tests. A few refused to coöperate, some did not speak English sufficiently well, others were hurried away before the examination was completed, and there were a number of women suffering from mental disease for whom such a test would have had no value. Two hundred and seventy-six of the women, however, were tested by the Terman intelligence test. The following table gives the results:

Charge	Total		Normal		Dull Normal		Border-Line		Defective	
	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
Incorrigible	107	100.0	16	15.0	29	27.1	33	30.8	29	27.1
Prostitution	149	100.0	28	18.8	37	24.8	46	30.9	38	25.5
Others	20	100.0	4	20.0	4	20.0	8	40.0	4	20.0
Total	276	100.0	48	17.4	70	25.4	87	31.5	71	25.7

For the whole group examined, the normal and dull normal constituted 42.8 per cent, while the border-line and defective together were 57.2 per cent; for the incorrigible group, the corresponding percentages were 42.1 and 57.9; and for the prostitution cases 43.6 and 56.4. This table shows that 17.4 per cent of the 276 cases tested have normal intelligence, which is expressed by an intelligence quotient of 90 or above. This means that they pass successfully the tests required of a normal child of the age of fourteen years and five months. The next group, the dull normals, make up 25.4 per cent of the cases. These individuals, with an intelligence quotient of 80-90, correspond in mental capacity to children of the age of twelve years and ten months to fourteen years and five months. The so-called border-line cases, 31.5 per cent of the series, have the mentality of children of the age of eleven years and four months to twelve years and ten months. Those termed mental defectives have an intelligence quotient of below 70—that is, in the tests they can compete mentally only with children less than eleven years and four months. Over one half of the cases—57.2 per cent—therefore, are defective or subnormal in intelligence. Five of the 71 defectives had actually been in institutions for the feebleminded. For the low-grade defectives, or for those who showed marked sex delinquency, admission to custodial institutions was recommended. Such a case is given in the following record:

> *Case 1.* This girl of nineteen began to have relations with boys before she menstruated, and before fifteen she was going with men and accepting money. Three years ago she had a still-born child and last July she had another. Her mother was dead, and her father worked at night, so that it was easy for her to bring men to her home. Her mental age was 8.6 years. She was treated at the Kingston Avenue Hospital for syphilis; then returned to the court. Because of the necessity of making an immediate disposition, she was sent to the House of the Good Shepherd.

On the other hand, mental defectives with good habits of industry, who are not dominated by the sex instinct, can get along in a protected environment if not taxed beyond their limitations.

Cases Sent to Bellevue Hospital for Observation

When a woman was found to be seriously defective, with vicious social tendencies or mentally sick, an effort was made to have her sent to the Psychopathic Ward of Bellevue Hospital to be observed and from there committed to one of the state institutions. As previously mentioned, eighteen individuals were admitted to the Psychopathic Ward of Bellevue Hospital, but two additional cases who were first observed on probation were also sent there. Of these twenty cases, seven were mental defectives and five of them were committed to proper institutions. One defective was removed from Bellevue by her relatives, who refused to coöperate in the plans for commitment; the other was, through a mistake, dismissed from the hospital. On account of the intricacies of legal procedure, most of these cases were simply admitted for observation on the recommendation of the examiner and were not committed to the hospital by the magistrate. Ten women were considered insane and eight of these were committed to state hospitals for the insane. One of the other two was returned to her relatives in her home state; the other woman was considered committable, but the judge permitted her relatives to take her in custody and she later shot herself. The three women dismissed from Bellevue as not insane or defective represent very difficult problems. One of them will be discussed under the group of constitutional psychopathic inferiors.

This answers directly the question, how many were actually committed—five defectives and eight insane. As a matter of fact, the examiner considered 48, or about one-sixth, of the 300 as utterly unfit for community life. Of these, fourteen suffered from mental disorders (ten mentioned above as sent to Bellevue Hospital, three sent to the workhouse, and one to Kingston Avenue Hospital). All these were serious cases and not hysterias or minor disorders. Thirty-one defectives and three from the border-line-intelligence group complete the list of 48. Two of the border-line cases were sent to the House of the Good Shepherd. The other one, who has the following history, was given probation:

Case 2. This woman was anæmic in appearance and had a goiter that was causing mild symptoms. She was a sickly baby, has always been weak, and is still subject to "bilious headaches". According to her statement, she finished the 8B grade at fourteen, failing in only one grade. Her intelligence level was 12.2, intelligence quotient 76. She had earned good wages, but had not been able to stick to a job long. After she had been deserted by the husband whom she had married at sixteen, she had an illegitimate child. In December 1919, she had another child which was premature and died, and since then has induced two abortions. In July 1920, she married the man by whom she had had the last three pregnancies. He was cruel to her, and she left home to escape him. She was arrested in a hotel and admitted that she had had relations with the man with whom she was found, but she denied soliciting or receiving money. She said simply, "I thought if I could do a favor, I would do it." She admitted that she could not control her sexual cravings and realized that she was easily led. Though her intelligence level is relatively high, she shows certain characteristics of the feebleminded, and her sex life is such that one would consider her a proper institution case.

The disposition of the thirty-one feebleminded was as follows: seven were sent to Bellevue Hospital, nine to the House of the Good Shepherd, six to Kingston Avenue Hospital; five were given probation; two were sent to the workhouse; one, long in prostitution, was sent to the New York State Reformatory for Women at Bedford with the purpose of having her admitted to the defective-delinquent group there. The other girl was one of the witness cases referred for examination. A greater effort should be made to get these feebleminded girls committed to custodial institutions where they can be held indefinitely. They cannot be considered responsible, yet after a few months at the House of the Good Shepherd they will again be at large.

The border-line-intelligence group, which makes up almost a third of the 276 who were given the Terman test, is a most difficult set of girls to adjust to community life. They have an intelligence quotient of 70-80, which corresponds to that of children of normal ability of the age of eleven years and four months to twelve years and ten months. If these girls have stability and good habits of work, they can support themselves in the industrial world. The majority of them, however, are unstable; many of them have the characteristics of the feebleminded—that is, they are suggestible, easily led, the prey of others, as, for example, the case just mentioned (Case 2). When one looks through the border-line group,

one is struck by the great number of serious problem cases. The following record of one from this group will be recognized by court workers as a familiar type of the so-called "incorrigible girl":

Case 3. Marie, aged seventeen, was born in New York. Her father is dead, her mother does day's work, she lived in an orphanage from the age of three to eight. She first attended parochial school, then went to public school, leaving at fifteen in grade 8A. She had failed in two grades. At sixteen she went to work in a factory, but after three months she left to become a telephone operator. After following this occupation for seven months she was discharged, probably for inefficiency, but the immediate occasion was a temper tantrum and a quarrel with a fellow-worker. For six months she has had no work and has idled her time away, reading novels during the day and running about the streets at night, not getting home until two in the morning. She was "disgusted" because she lost her job and did not think it worth while to bother about another. One morning she had a fit of temper and threatened her brother with a butcher knife, because he talked to her about going to work. The mother was obliged to call an officer and brought the girl to court. She was sent to Kingston Avenue Hospital because the routine examination revealed the fact that she had gonorrhea; later she was sent to the House of the Good Shepherd. She had been immoral five months before her arrest, with a man whom she met while strolling at midnight on Broadway. She liked him and went willingly with him a number of times; then he dropped her. This experience made little impression on her, and she did not feel that it played any special rôle in her life. Her mental age is 12.5 years, intelligence quotient 77. Her general health had been good, but she had been nervous from the age of seven to fifteen, restless and jerky, a condition that she described as "a touch of St. Vitus dance". Such nervous instability, temper, fits, indifferent moral attitude, and mediocre mental capacity, are common attributes in the incorrigible group.

The Incorrigible Girls and Prostitution Cases

It must be emphasized again that the work was not undertaken as a statistical investigation. The record in almost every case is the result of one interview with the girl. However, one can glean from these records certain important impressions. Though a girl more often than not gave false information in order to conceal her identity, she was usually willing to coöperate in the intelligence test, to answer medical questions, and to enter into a discussion of her personality, so that so long as one kept to such topics one could gain quite valuable knowledge. In comparing the incorrigible group with the prostitutes, one finds that their intellectual level is practically the same—that is, approximately 57 per cent are defective or subnormal in mentality. We also find that 63.1

per cent of the incorrigibles and 66.8 per cent of the prostitutes did not finish the eighth grade in school; 11.4 per cent of the incorrigibles and 16.2 per cent of the prostitutes entered high school, but did not finish. Among the incorrigibles we had no high-school graduates, but there were five in the prostitute group.

Of the incorrigible girls, 25 stated that they were Protestants, 14 Hebrews, and 75 Catholics. Among the prostitution cases, 56 were Protestants, 27 Hebrews, and 77 Catholics.

In regard to ages, only ten of the 114 incorrigible girls were over twenty-one. The majority of the prostitutes were between twenty and thirty; 143 of the 160 were under thirty-one years of age; one was over forty; and two were under sixteen.

As to nativity, the groups ran about the same; 81.6 per cent of the incorrigibles and 78.7 per cent of the prostitutes were born in the United States. The homes of 19 of the incorrigible group and of 68 of the prostitution cases were not in New York City. The nativity of the two groups was as follows:

Nativity	Incorrigible Girls	Prostitution Cases
United States	93	126
Africa (British)	..	1
Austria-Hungary	1	7
Belgium	..	1
Canada	..	5
Cuba	1	..
Denmark	..	1
England	..	3
France	1	1
Ireland	1	..
Italy	6	2
Norway	1	..
Porto Rico	1	..
Russia	8	7
Sweden	..	1
Switzerland	..	1
West Indies (British)	1	2
Not known	..	2
Total	114	160

In the matter of the number of times under arrest the groups approximate each other: 70.2 per cent of the incorrigibles were in court for the first time, as were 76.2 per cent of the prostitutes. Thirteen of the incorrigibles and six of the prostitution cases had records in the Children's Court.

It must be remembered, however, that many of the prostitutes are out-of-town girls. The following tabulation shows the number of arrests for the two groups:

Number of Arrest	Incorrigible Girls	Prostitution Cases
First	80	122
Second	26	24
Third	7	6
Fourth	1	2
More than fourth	..	6
Total	114	160

When one uses the term prostitute, it must be kept in mind that these were not the old-timers or street-walkers, but younger women of the better type. The incorrigible girl usually lives at home and is brought to court by her relatives, so it is not surprising that only 16.6 per cent come from other places, while 42.2 per cent of the prostitutes are from out of town; many of them have drifted here as chorus girls. We find that only 4.4 per cent of the incorrigibles were chorus or "show girls", but 14.4 per cent of the prostitutes give that as their occupation, and 20.6 per cent of the prostitutes were not working; some had not had a job for weeks or months. Reports on investigations of positions and work records were not available at the time of the psychiatric examination: doubtless many of the others were being supported instead of working.

The occupations of the incorrigible girls and the prostitution cases are shown in the following table:

Occupation	Incorrigible Girls	Prostitution Cases
Factory	45	27
Telephone operator	17	11
Clerical	15	22
Domestic	8	16
Waitress	4	11
Chorus and shows	5	23
Dance instructor	4	3
Usher	2	..
Elevator operator	..	3
School	3	1
At home (married women)	..	10
None	11	33
Total	114	160

The border-line case cited above (Case 3) represents the unstable, neurotic, mentally subnormal girl, characteristic of the incorrigible type. The prostitute type does not so frequently give a history of nervousness and neurotic traits, pointing to a neuropathic constitution. She is lazy, vain, morally lax. She wants the silk stockings and the fur coat and goes "the easiest way" to get them. It is usually not sex cravings, but a placid, indolent nature with a desire for finery, dancing, and excitement, that is back of her sex delinquency. She is exceedingly shallow and empty emotionally; in fact, many of them say frankly that they have never loved any one, that they care for no one but themselves. The high percentage in the prostitute group of "show girls" and girls not working, together with a study of the tabulation of the neurotic traits, confirms the impression that one can sort out different types to represent the two groups.

MANIFESTATION OF NEUROTIC CONSTITUTION

NEUROTIC TRAITS	INCORRIGIBLE GIRLS		PROSTITUTION CASES	
	Number	Per cent	Number	Per cent
Nail-biting	44	38.6	41	25.6
Enuresis (at least to eight years of age)	25	21.9	21	13.1
Excitability, instability	30	26.3	29	18.1
Sleep disorders	22	19.3	13	8.1
Temper tantrums	26	22.8	16	10.0

The distribution of these traits among the individuals of the two groups is as follows:

	INCORRIGIBLE GIRLS	PROSTITUTION CASES
Number having only one of these traits	28	45
Number having two of these traits	25	23
Number having three of these traits	16	9
Number having four of these traits	4	4
Number having all five of these traits	3	..
Total number with these traits	76	81

From the above table one sees that 66.7 per cent of the incorrigible girls give evidence of poor neuro-muscular balance and poor emotional control. This is a decided increase over the 50.6 per cent of the prostitutes that show such traits. One will note, too, that sleep disorders and temper tantrums are more

than twice as common among the incorrigibles; also that the percentages for the other three traits are much greater. The terms of the table need little explanation. Nail-biting, picking at the nails, and knuckle-cracking are evidence of tension. Enuresis (bed-wetting) may be indicative of poor neuro-muscular control, but is frequently a lack of habit training. It is striking how often this habit persists to the age of puberty or later. Under the caption, "Excitability and instability", one refers to such statements from girls as that they have always been considered nervous, that they are easily frightened, that they get excited or "hysterical" at the least little thing; in fact, this heading covers a variety of descriptions of vague states of uneasiness, apprehension, tension, and poor emotional control. Sleep disorders were not recorded unless they were definite and quite marked, such as the habit of sleep walking, repeated disturbing night terrors, and the like.

In addition to the above-mentioned traits, the following conditions were found:

	Incorrigible Girls	Prostitution Cases
Retarded physical development	11	10
Chorea	6	6
Major hysteria	3	5
Speech defect	2	..

Sex and Marital Life

A few facts regarding the sex and marital life of these women may be of interest from the social and eugenic standpoint. Local examination of the 114 incorrigible girls showed that 90, or 78.9 per cent, of them had had intercourse. Two of those who had not had sex relations were perverts. Eleven of the 114 were pregnant at the time of arrest; seven had had an illegitimate child. Eleven of the incorrigible girls were found to have been married, but in only one of these cases—possibly two—could one hope to make anything of the marriage. Seventy-five of the 160 women arrested on a prostitution charge acknowledged frankly that they were promiscuous. Four of the prostitution group were pregnant at the time of arrest; thirteen had had an illegitimate child; and fifteen others had been pregnant illegitimately, five of these confessing to criminal abortions. Eighty-five in the prostitu-

tion group stated that they were single. Of the seventy-five in this group who said that they were married, four were widows and forty-four were separated from their husbands. So one sees that, besides venereal disease, there are very serious social problems to be met in these court cases.

Types of Mental Disorder

It is stated above that ten women considered insane were sent to the Psychopathic Ward of Bellevue Hospital; eight of these were later committed to state hospitals. The diagnoses in these cases were: dementia praecox 4, manic-depressive insanity 4, dementia paralytica 2. But these are not all who showed psychotic symptoms. In outspoken conditions, the judges were ready to send the patients to Bellevue, but in less pronounced states it was difficult to secure observation. Three patients of the manic-depressive type were sent to the workhouse. One young woman, probably a case of dementia paralytica, showed marked mental deterioration, but was sent to Kingston Avenue Hospital for the treatment of syphilis. One only wishes that the subject of mental hygiene had been as much emphasized and its importance as well understood as the question of venereal disease, for venereal disease is really properly and adequately handled. The psychiatrist in the court feels the urgent need of an adequate scheme of personality study and a definition of terms referring to defective and abnormal personalities. The question of affective capacity constantly presented itself. A few of the women were quite definitely depressed, and one felt that their period of inactivity (no job) was a result of this mental state, yet it was strikingly seldom that one got such a mood description as "downhearted", "sad", or "blue", terms so familiar in true depressive states. On the other hand, "disgusted" was a very common reply. This seemed to cover discouragement with a certain feeling of inner dissatisfaction and discontent. While the term has been applied to a group, one feels that though there were many with low affective capacity, there were not many without some affective response. The contact with the women was much too brief and cursory to judge this well. So many excused their sex delinquencies with the explanation

that on the first occasion they were intoxicated; many that they had been betrayed by a promise of marriage. A number had been complainants in rape cases, yet seldom did they offer the early experience as an excuse. One wonders, however, whether such an early experience does not act as an etiological factor. One very important stimulus to the younger girls is the sort of talk they hear in factories. Repeatedly girls have said that they were innocent until they went to work; then the conversations that they overheard made them curious and lowered their standards of conduct. Masturbation was rarely admitted. Doubtless it is less common in these women who are not sexually repressed. As regards general health, the histories were remarkably good. It was also unusual to find the chronic invalid or psychoneurotic type. That no girls were encountered with paranoid tendencies is probably explained by the fact that these court individuals are usually drifters, lacking in aggressiveness and self-assertion. There are no epileptics in the series. The history of one girl's disappearance from home was suggestive of fugue states, but she had no attacks. Her sister was a deteriorated epileptic. There were several examples of major hysteria. A great many women drug addicts go through the court, but they are not the younger women and only one was examined. This woman, seen at the request of the judge, had long been in prostitution.

Women who have several records are, as a rule, not investigated by the probation officers. The judge occasionally referred an older woman to the psychiatrist if she seemed abnormal. There was one woman who was well known to the attendants of the prison and long considered "crazy" by them, yet nothing had been done to eliminate her from the list of recidivists. The psychiatric examination led to her commitment. The following brief report made to the judge gives the main facts:

"According to the finger-print record, this woman has been convicted in this court thirteen times the last ten years for prostitution. She shows marked speech, memory, and writing defects, all symptoms of dementia paralytica. In manner she is euphoric, boastful. Some of her delusions are as follows: she is the richest woman in the world; she is married to

the son of the King of Saxony; Rockefeller and Roosevelt are her uncles and Katherine B. Davis is her aunt. She denies hallucinations. In the memory test there are many foolish discrepancies. She gives her age as thirty or thirty-six, but states that she was born in 1914. She is not oriented as to time, is unable to give the month or the year, but states that it is wintertime, about Christmas. She cannot give a consistent account of her life—in fact, is quite demented, and state-hospital care is urgently recommended."

Normal and Abnormal Personalties Types

Though a well-balanced mental defective or an individual with border-line intelligence may succeed admirably in a favorable environment, in this discussion of normal and abnormal personality types we shall assume that the person shall have a mental capacity equal to that of a child of twelve years and ten months or above—that is, an intelligence quotient of 80 or above. We have taken the records of the women of the incorrigible and prostitute groups of this mental level, the normals and dull normals, and have studied the 110 cases with reference to personality traits, adaptability, nervous instability—that is, the presence or absence of neuropathic symptoms—the capacity for natural affection and adequate emotional response, the instinctive sexual demands, habits of work, and the presence or absence of pathological reactions. With these points in mind, we sorted the individuals into gross types according to the table given below.

Type	Total	Incorrigible Girls	Prostitution Cases
Normal	30	17	13
Constitutional psychopathic personality	7	4	3
Constitutional psychopathic inferior	30	12	18
Constitutional affective defective	43	12	31
Total	110	45	65

The insistent question as to how many of the girls were normal came to be an annoyance, but one could easily counter with the reply, "Give me your standard of normality." The psychiatrist accepts the fact that there are varying standards of normality and is soon lost in the study of the individual and

his assets and modes of reaction and self-expression, not as compared with any theoretical standard, but with reference to the question wherein this person, with his particular equipment, is making a failure. From the standpoint of conventional behavior, one could say offhand that all of these women are abnormal, since they have deviated from social standards and have broken the laws that regulate social conduct. Probably most people mean by the question, how many have the capacity to make a successful social readjustment. Various case records from the thirty individuals of the normal type will be given to show the wide range of personalities within the group.

Case 4. Anna is a sixteen-year-old girl who lived with her married sister in a very good home. Her mother is insane and was committed to a hospital six years ago. Anna was then ten years old, and she lived in a Catholic institution until one year ago. She had had no serious illness and no neuropathic traits. She finished the eighth grade in the parochial school, became a telephone operator, and has worked steadily, earning a good wage. Four weeks before being brought to court on a charge of incorrigibility, she had a quarrel with her sister about her hours and her recreation. She felt that she could not be in by eleven o'clock at night; therefore she ran away and took a furnished room. She was "crazy" about dancing and went out every night. She was going about with a man whom she met at a dance hall and was planning to go to Atlantic City with him, where he had promised to get her a better job. But the night before her departure she was arrested by a policewoman who had been searching for her. The girl was talkative, lighthearted, pleasure-loving, with no realization of the danger she had been in. Her mental age was 14.3 years, I. Q. 89, and she had no special difficulties except an undisciplined temper and a craze for dancing. Examination showed that she was a virgin and she was remarkably free from curiosity and ruminations about sexual matters.

Case 5. Mary is an eighteen-year-old girl from a neighboring city, one of the prostitution cases. According to her story, she was on Broadway when a man came up and asked her to take a ride, offering her five dollars for a good time. She was arrested as she was getting into the taxicab. She stated she did not intend to prostitute, that she thought she would have a gay evening, but did not intend to yield to intercourse. She had arrived in New York the evening before, had stayed in the station overnight, and had spent the day looking about for work. She had been discontented at home, quarreling with her parents because they objected to her friendship with a certain girl. She admits now that her father was right in his opinion of this friend, for it was this girl who had taken her into bad company. Twice she had had intercourse after becoming intoxicated at parties. Her parents have no knowledge of these experiences. Her mental age was 14.10, I. Q. 92. She had graduated from public schools and had been a telephone operator for

one and a half years. She has never been nervous, has an even temper, but thinks she has a "mean disposition", for she carries grudges and has revengeful thoughts, though she seldom puts them into execution.

Case 6. Another prostitution case, Martha, a widow, aged twenty-six, from St. Louis, admitted that she solicited. She married at sixteen and has three children. Her husband was killed in an accident three and a half years ago while she was carrying the last child. The $1,000.00 which she obtained from his insurance was used up during her pregnancy and the sickness that followed her confinement. She owned her own home and tried to make ends meet by keeping roomers, but she was a poor business manager. She finally had to mortgage her property, and five months before her arrest she was forced to sell out. She placed the older child in an institution, put the two younger ones out to board, and came to New York to see her sister. She returned home after a few weeks, but soon came back with the plan of opening a rooming house here. When her sister, who is thrifty, refused to lend her the money for that purpose, she left her and went to live at a hotel. After four days she had no money to meet her bills and solicited. She had a mental age of 13, I. Q. 81. She did not appear nervous, but said she had worried herslf to death, and complained of feeling nervous since the birth of the last child. On being questioned, she admitted that for the last year and a half she had been intimate with a man who had been a roomer in her home. He had not asked her to marry him, but had given her sums of money and had helped in the care of the children. He had become a petty officer in the navy and his ship was due here when she planned her first trip to New York. At the time of that visit she saw him frequently. Her situation is largely accounted for by this infatuation and her poor judgment. An interview with the sister confirmed all the information that the woman had given.

Case 7. Caroline, aged twenty-one, a Philadelphia girl, is a prostitute case. Her general health had been good and she had no neuropathic traits. She went to high school for three years, leaving at seventeen to go to work. She was employed first in a factory; then was a telephone operator for a year, but returned to factory work, making paper portfolios, because she liked it better. In May 1921, her mother became ill and died. After her mother's death, she was sad, restless, and felt indifferent about working. She stayed at home until the end of July, when she went to Atlantic City and became a "hostess" in a café. It was her duty to dance with men who had no partners. She and her companion say that they were closely observed there, and that nothing improper went on. After working in the café five weeks, the girls came to New York and were arrested the night of their arrival. In Atlantic City they had met a man who told them that he was a "booking agent for chorus girls", and would get them places in a chorus, and they met him there by appointment. He warned them not to enter into conversation with any one on the street, but they had no sooner left him than another man spoke to them and invited them to supper. They ate with him and had gotten in a taxicab with him when another taxi drove up, stopped them, and arrested the girls. Caroline's companion was a bleached blonde, aged nineteen, of border-line intelligence, eager for

show life. While she denied prostitution, she admitted immoral relations and was apparently without conflict about her behavior. Caroline, on the other hand, was pleasing and attractive in appearance, kindly and affectionate in disposition, with no real desire to go on the stage. She came to New York because, since her mother's death, she had not been able to be contented at home. Though her mental age—17.6 years, I. Q. 109—was above the average, she was quite lacking in self-confidence, self-assertion, and ambition. Her older sister who came for her confirmed this impression, saying that Caroline turned over to her her pay envelope unopened, and that she bought her clothes for her. The girl had first had intercourse two years before with a man with whom she was in love. After two months this affair broke up and she soon became intimate with another man. When asked about marriage, she said that she felt that she was too changeable—that she thought she had really cared for the two men, one after the other, but now she looked upon the affairs as infatuations and she believed that her affections were too shallow; she did not trust herself to marry. So we have a girl, well endowed mentally, with some capacity for feeling, yet a weak, drifting individual, who can probably be molded by good influence as easily as by bad.

Constitutional Psychopathic Personality

In the title of this group it will be noted that the modifying terms "inferior" and "defective" are omitted, the emphasis being on the adjective *psychopathic*. These individuals show a better social attitude, a greater emotional capacity. Since they are more sensitive in nature, they are more likely to show symptoms of mental disorders that arise on the basis of conflict of instincts with conventional standards.

Case 8. A colored girl, a high-school student, not a sex offender, was charged with incorrigibility because she ran away from home repeatedly. This overwhelming desire to get away and to be alone is usually associated with the menstrual period. She feels melancholy, "gets a hard feeling toward every one". Formerly she went to the library, where she sat turning the pages of books, but accomplishing little reading. After the librarians learned about her, they questioned her, and she began to drift about the city, often spending the night in the subway. The girl is active in church work and eager to complete her education and follow out her ambition to be a missionary.

Case 9. Bessie, aged eighteen, is a prostitution case. At the age of eight, she had diptheria and was critically ill, and the two following years she had St. Vitus Dance. On account of heart trouble, she was not permitted to walk much and remained in bed a great deal. She was troubled with enuresis until ten years old. Because of a chronic nasal discharge, she has had two operations within the last year. After finishing parochial school, she attended commercial high school for eight months. She was first employed as a telephone operator, but resigned after several months on account of the nasal discharge. Then she tried

working in a department store, but left for the same reason. She was a dancing instructor for a time, but gave that up after two months and returned to the telephone company. She left there because she felt too weak to work, and for the last four months before her arrest she had not been employed. Her attitude about the nasal trouble is distinctly abnormal. She gave up all jobs because she thought she was not wanted, that the nasal discharge was offensive to others. She said that the discharge had a foul odor, that it made her weak and poisoned the air that she breathed. As a matter of fact, no odor at all was noticeable as one talked with her. Her mother is dead and she lived in an orphanage until the age of fifteen, then with a married sister of whom she is very fond. She could not get on with her sister's husband and left her, taking a room in the same house where her father lived. She cooked for him and herself, but she found this too lonely, and with his consent she went to live with a girl friend. This friend had trouble with her aunt, with whom she lived, so the two girls went away and took a furnished room. They had $20.00 between them, but this soon went, and constant moving was necessary since they could not meet the rent. She admitted that they had solicited, but she had avoided intercourse whenever possible. She would go to a restaurant with a man, get a meal, then make some excuse, or she would go to the ladies' room and slip away. At the time of their arrest, the two girls had given up their room, had checked what clothing they had, and had spent the night in the Pennsylvania Station. The next day they solicited two men who happened to be detectives. The girl has an intelligence level above the average—mental age 17.5, I. Q. 108—but as we have seen, she was an invalid child with neuropathic traits. She now feels weak all the time and has headaches. She has been quite despondent and worried a great deal. She was troubled with insomnia, could not get to sleep, and smoked many cigarettes. She maintained that up to six months ago she did not have exact sex information; she had pondered about such matters, but had asked no questions. Last summer after being intoxicated at a Coney Island party, she had sexual relations for the first time, but she had liked the man and had willingly gone with him several times afterwards. She denied that she had had intercourse again except on one occasion when, after soliciting, she had been unsuccessful in avoiding it. As she talked, she cried constantly over her disgrace and the sorrow she had brought to her father. What was back of her pathological attitude about the nasal discharge could not be determined during the interview.

Constitutional Psychopathic Inferiors.

This group is not at all well defined, but in the main one can say that they are egocentric individuals, with difficult personality traits, with symptoms of nervous instability, poor balance, and lax moral standards. They are frequently dishonest and extremely undependable. They are usually active trouble makers, often given to violent outbursts of temper.

Case 10. Ruth, aged seventeen, an incorrigible girl, was brought to the examiner because she had broken her probation. During the last year

she had run away from home five times. This time she was accused by the detectives who found her of consorting with negroes and practicing perversions. She was a rather pretty girl who coöperated well in the examination, giving in detail her version of the difficulties. Her intelligence was average—mental age 15.6, I. Q. 96. Her parents were strict orthodox Jews, and her earlier runaways were due to their uncompromising attitude and her craving for excitement. She was ambitious socially and felt that their home was not nice enough for her friends. She had had about two years in high school and then stayed at home while her mother attended to the shop. She had never been employed, and said she would not care to have an ordinary job, but might like to work in a first-class store and sell lovely things to nice customers. She confessed that she had had immoral relations with a friend two weeks before she left home the first time. She was partly threatened and partly persuaded into the act, but thereafter she was easily aroused and had repeated experiences. She denied the charges which the detective made, but admitted that she had been in colored cabarets. She did not deny that she prostituted when in need of money. This, however, was not without some conflict, for she said, "I know in my heart and soul I am not a prostitute, yet what else am I doing?" It seemed useless to send this girl home, yet there is no institution for Jewish girls. Probation officers and relatives were at a loss to know what to do. At that time it was reported that girls could be observed in the Bellevue Psychopathic ward and be admitted to Bedford Reformatory from there. After being at Bellevue for one month, she was returned to the court with the recommendation that she be committed to Bedford. Since the charge against her was incorrigibility, the judge again permitted her to go home. The hospital record stated that she undermined the morale of the ward, spoke disparagingly of other patients, had outbursts of temper, and became quite threatening in her attitude. It was also stated that she openly boasted of her immoral acts. After she went home, arrangements were made for her to reënter high school, but her teachers had to speak to her about her manner of dress and excessive use of rouge. They also said that she talked to other girls about her sex experiences. She deceived her parents and teachers and within a few weeks she again disappeared.

Case 11. Edith, aged twenty-six, was arrested on a prostitution charge. As a child this woman had many illnesses, though none severe excepting scarlet fever. She was badly spoiled and "extremely nervous". She could not sit still, trembled at the least excitement, was apprehensive and given to worry. She left high school at the end of the first year, because she "had stage on the mind". She went immediately into the chorus of a musical comedy. She was then sixteen and she has been in chorus for ten years, never able to advance because of nervousness. Five years ago she was offered a place in the cast, but had to refuse because of the lack of self-confidence. At present she complains that she cannot sit still, that she is always dissatisfied, never contented to be in one place more than a week at a time. She feels that her brain is working all the time, she cannot relax, feels all knotted up inside, and cannot sleep. She describes herself as headstrong and stubborn, yet says that she gets along well with every one. Her mental age is 16 years, I. Q. 100, which is taken as normal. In regard to her sex life, she was infatuated

with a man at nineteen and had immoral relations; then she was kept for several years by another man. While she denies that she is promiscuous, she pleads guilty to the charge of soliciting in a hotel. Her excuse is that she was out of money. She takes the matter very lightly and is not at all distressed about her situation. When asked about pervert practices, she denied them, then added, "Many crazy women have chased after me. I'll have to try that next."

Constitutional Affective Defective Type

In taking up this last group, one must emphasize again the point that there are no sharp lines of demarcation between the groups. They have this point in common—there are no cases with mental defect. In the normal class were those of better balance, with little nervous instability, and with a minimum of neuropathic traits. They have some capacity for natural affection and normal emotional response. This is shown in their reaction to their arrest. These women, as a rule, felt the shame of a court record. The experience brought them to a realization that they were drifting in a downward direction, and this was a decided point to the good in rating them above the inferiors. The next small group represent those who have a better sort of personality, but they show evidence of distinctly pathological processes in their mental life. One girl, who has been briefly described (Case 8), was subject to states of dissociation; the other (Case 9) was an example of what is known as the chronic invalid or psychoneurotic type. This girl would probably not have solicited had she had a good home, though she would probably still have been an invalid. Her excuse for soliciting was that she was too weak to work, but this "weakness" had its origin in false notions about a chronic nasal discharge. The third group, the psychopathic inferiors, are inferior from many standpoints, stability, adaptability, poor balance emotionally, and inferior standards of conduct. It is somewhat of a residue of cases that do not fit the other groups.

The women of the last group, the constitutional affective defective type, have a minimum of the explosive and impulsive characteristics so common in the psychopathic inferiors. They have little of the nervous instability, and seldom have a history of neurotic traits now or in early life; they are much more placid in nature and not inclined to stir up trouble. Phy-

sically they are inert, and it seems that their only form of self-assertion expresses itself as self-adornment. They are the "dolled-up", artificial type, and must have the latest "craze" in dress. Since they are constitutionally low in energy, they cannot possibly acquire such possessions with their earnings. In fact, most of these girls did not bother about a job at all; they were glad to be "kept". They frankly admitted that they were lazy. Since they have little capacity for real affection, and are usually without any sexual reaction at all, intercourse was a matter of indifference to them. They knew that it was expected and they simply "paid". In the course of the interview, after as much of the personal history as possible had been obtained and the examiner had some knowledge of the girl's family and friends, the girl was asked which person meant most to her—whom she had liked best or to whom she had been most attached. So often one got the answer, "I never really cared for any one", or "I never loved anybody." To sum up, the striking points in these histories are: the lack of natural affection, the lack of energy, and the lack of normal sexual stirrings. To compensate for these deficits, the girl finds her satisfaction in personal adornment, in an artificial, striking, cheap-rich style of dress. One naturally characterizes these individuals as shallow or superficial. On account of the emptiness of their natures, they are deprived of the satisfaction that normal people derive from work, friendships, family relationships, and desire to win approval.

Case 12. Pauline, aged eighteen, was a prostitution case. This girl had been brought to court by her aunt on the charge of incorrigibility in June 1920, and had been given six months' probation. She was seen by the examiner in January 1921. She had left her aunt's home, had taken a furnished room, and had been arrested for soliciting. She had always been strong and well, never nervous in any way, no neurotic traits. Her mental age is 14.5 years, I. Q. 90. In disposition, she is placid and even-tempered. When asked what she considered her worst fault, she said that she was lazy. She hated to get up, "fooled around" until it was too late to go to work; then it was easier to go with men. She had had intercourse at sixteen while intoxicated, but she refused to tell much about this experience. She admitted that she had been living with a man, also that she solicited, and that she had had no regular job for four months. She is several months pregnant. On account of gonorrhea, she was sent to the Kingston Avenue Hospital. In the hospital the women do not wear their own clothes, and most of the girls are hardly to be recognized when they lay off their "make-up",

but this one was "dolled-up", rouged, had her eyebrows plucked and carefully penciled. When told that her appearance was conspicuously different from that of most of the others, she explained that this manner of dress was a "habit".

Case 13. Hannah, aged twenty-six, convicted of prostitution, was an intelligent woman, dressed in good taste, refined in manner. Her mental age was 16.2, I. Q. 101, and she said that she was a college graduate. (A report from the college that she mentioned showed that she had not been enrolled there, but letters received from her mother confirmed her statements regarding her home life.) Her general health had been excellent, and she was in no way nervous or unstable. Her family live in the West and are in good circumstances. She came East to go to school. On account of her ambition to go on the stage, she also attended classes in a "school of oratory". While in the East, she had a love affair and entered into sexual relations, became pregnant, and had a miscarriage. After she finished school, she taught in a high school for one year, but her stage ambitions were pressing, and she satisfied these cravings by becoming a Red Cross entertainer on a voluntary basis. Her parents have always supplied her with some money, but not enough for the pleasures she desires. For a number of months she was a man's mistress in a city in the Middle West. Over a year ago she came to New York hoping to get on the stage, but she made no real effort to attain her ambition. She went home this summer, but returned in a few weeks, taking a room with the girl with whom she was arrested. She denied that she prostituted for money, but said that she must have gayety and entertainment and was willing to pay the price. Intercourse meant nothing to her, and since she had "lost her virtue", what did it matter? She had not thought much about the way she was drifting in life and never worried over moral issues. The desire to go on the stage, she thought, arose from vanity. It was found that she had syphilis, and she was sent to Kingston Avenue Hospital.

Any one familiar with mental disorders is struck by the three characteristics that occur together—namely, the inadequate emotional reaction or lack of affection, the lack of energy, and the lack of natural sexual feeling. These represent exactly the domain of the personality that is disturbed in the affective psychoses, of which manic-depressive insanity is the prototype. It should be made clear that in patients suffering from this mental disorder, it is not at all a question of a *deficit of these feelings,* but a disturbance in the working of these forces. An individual must necessarily have capacity for feeling and affection in order to react to events with such an illness. In the manic-depressive type of disorder there are two phases or pictures, as the name suggests. In a depression, the patient is sad, melancholy, and sees nothing ahead in life but doom and destruction. She sits in one place all day,

quite inert. She will tell you that her mind does not work as it did; she has difficulty in planning. She cannot make and carry out decisions. Moreover, she is aware that her affections have changed; her feelings have lost all their warmth, even her children do not seem like her own, and she is puzzled to know why she does not care for them. This depressed mood, loss of affection and interest, this diminution of mental capacity, are accompanied by a slowing up of all the bodily processes. The patient speaks very slowly in a voice that is hardly audible; she loses all desire for food, and her bowels become sluggish. Normal sexual desire and sexual response are in abeyance.

In the opposite phase of this disorder, there is exhilaration, an extremely happy, even hilarious mood. The patient is not aware of any sickness; in fact, she never felt better. She can think quickly, associations come freely, she is full of schemes, talks constantly, and is in never ceasing activity. This condition frequently reaches the degree of a violent excitement. With the overstimulation psychically and physically, the judgment becomes poor, and the patient may do all sorts of absurd or indiscreet things, especially since there goes with the condition an arousal of sexual cravings with a lack of normal inhibitions. The principal causal or precipitating factors in the affective disorders are emotional shock or strain or a conflict in the instinctive life; whereas, in the women grouped as affective defectives we find an indifference to their past experiences, a lack of conflict or distress. Now we know that there is an hereditary factor in the affective disorders, that they tend to run in certain stocks, just as we know that feebleminded beget feebleminded. This indicates that *affect* (a term referring to the dynamic forces of personality, feelings, affection, and driving emotions) is a fundamental unit in a person's make-up and that the individuals of this group are characterized by their affective defect. Just as there are degrees of mental defect, so there are degrees of affective defect. The comparison of affective defect with intelligence defect is made simply to emphasize its inherent, fundamental nature. Individuals of mediocre or low intelligence may be sensitive, loyal, and affectionate, and they may and sometimes do have affective disorders of the manic-depressive sort.

Summary of All Cases

The discussion of normal and abnormal personalities has been confined to the prostitute cases and incorrigible girls who ranked above the border-line level in the intelligence tests. The examiner has gone over the 300 cases with a view to grouping them according to mental defect, personality deviation, and mental disease. The results are shown in the following table:

Normal type	33
Inferior or psychopathic personality types	129
Border-line intelligence	52
Mental defectives	71
Insane	14
Drug addict	1
	300

This classification on a double basis is far from satisfactory; it is merely an attempt to bring the 300 cases together in one table. It will be noted that the 71 feebleminded are presented together as a group, no attempt being made to study them from the personality standpoint. Any one who has had to do with mental defectives knows that they vary greatly in reactions and behavior and capacity for affection, but since they do not have the intelligence to analyze and describe their traits, one would not be justified in judging them by a brief examination, but would need to observe them in various situations. In the border-line-intelligence group, one sees a wide range of personalities. Those resembling the abnormal types are grouped with them, while 52 are allowed to stand, for with them low mental capacity, rather than abnormal or difficult traits, seemed to be the important factor leading to the arrest.

The terms constitutional inferior, constitutional psychopathic personality, and constitutional psychopathic inferior are not sharply defined and are often interchanged indiscriminately. Some accurate discrimination in the use of these personality terms will come out in the present intense interest in the study of personality traits and types of reaction. Until recent years the study of mental disorders was confined to observations on psychotic patients, so ill that they required hospital care. Pathological behavior that did not fall within

the range of the well-known disease pictures did not receive much attention. With the present trend of mental hygiene, it is the aim of the psychiatrist to understand each individual—his ambitions, capacities, and handicaps—and to try to find out just how his experiences have affected him and how his reactions to the events of his life have modified his attitude toward himself and toward society. With the spreading of the interest of the physician from the severe to the milder disorders, there has grown up a science of medical psychology, but for this, as for other sciences, there is a big field to be explored. Individuals vary so greatly in so many kinds of traits, abilities, defects, and modes of reaction, that it is futile to search for the "normal". What one can best do in the present state of our knowledge is to use descriptive terms and search for types.

In making reports to the judges, the examiner was extremely wary of making specific recommendations except for the insane and the low-grade feebleminded. The report consisted in a statement of the intelligence level, remarks concerning habits of work, nervous stability, emotional reactions, together with any information obtained that threw light on the reasons, motives, and circumstances that led the girl into a situation that made an arrest possible. The examiner had had no experience with correctional institutions or with remedial measures of that nature. As a result of this study of the 300 women, the opinion has grown more firm and definite that the problem of delinquency, antisocial conduct, and abnormal behavior is a very complex one that can be satisfactorily met only when judges, probation officers, criminologists, officers of correctional institutions, psychiatrists, and social workers pool their knowledge and experience. In fact, the problem is a community problem. The court is a clearing house for all sorts and conditions of people who are obviously making a failure in life. It should be a scientific, social laboratory of first importance. Of course, the problem of prostitution is a problem bigger than the court and will not be discussed, but to make the court work more effective there are many needs. A house of detention, where women can be held until investigations are made, is absolutely essential. Longer time than the customary forty-eight hours is needed, especially since within

this brief period it may not be possible to get in touch with any relative or friend of the woman. A good many of these offenders are not residents of New York City, and two days hardly allow time for an exchange of telegrams; one must remember, too, that often the information first obtained is false.

The five women probation officers are tremendously overburdened. Each day brings new cases for investigations that have to be made promptly and too hurriedly. These officers give an evening each week to seeing the girls who are on probation who are required to report to them, but time does not exist for active, constructive work with each individual beyond what can be obtained in these brief contacts. The judges come to the court two evenings a month to hold personal conferences with the women on probation and to discharge those who have finished their probationary period. The present court rooms are entirely inadequate. The desks of the five probation officers are crowded together in one small room, and opportunity for private conversation is entirely lacking. One is filled with wonder that the probation officers faithfully carry on their work in spite of the confusion that exists. It is not possible under present conditions to obtain a thorough investigation, especially of work, school, and birth records, in the allotted time. Important factors are constantly coming to light after the disposition of the case has been made. For instance, two girls in this series are under sixteen years of age. One of these, a girl of fourteen, who said she was twenty, refused to give information that would lead to her identity. In size and appearance she passed without question for an adult. She had normal intelligence. She talked freely of her experience, admitted that she prostituted, and was thoroughly familiar with the language and customs of women of the street. After she had been sentenced to the workhouse, a telegram that had been sent to the chief of police in a certain city which she had mentioned led to the finding of her mother, who was living here in New York. Besides the precocious physical and sexual development, there were other signs of disturbance of function in the glands of internal secretion.

The report as a whole shows that the court offers many important problems to the psychiatrist. The examinations should enable the judge to sort out immediately the low-grade

mental defectives and the insane. The reports should give the judge and the probation officers information concerning the personalities of the women that will enable them to handle the individuals with more insight. The results of the work should ultimately aid in the solution of correctional problems. The psychiatrist should be of assistance in following the probation cases with the probation officer. By getting in touch with the women in a medical way there is greater opportunity to help them with their personal problems. While it was the purpose in undertaking this study to limit the examinations to the incorrigible girls and first offenders in prostitution, the requests for examination of older prostitutes and the cases referred from other courts indicate that there is a great deal of mental defect and mental disease among the older prostitutes and the women arrested as vagrants with no homes.

In closing, the writer wishes to say that she is especially indebted to Miss Maude E. Miner, the executive secretary of the New York Probation and Protective Association. It was her interest and energy that created this opportunity for a psychiatrist to be present and work in the Women's Court. Dr. Anne T. Bingham, psychiatrist to the organization, not only acted as substitute at the court when the examiner could not be present, but also gave freely of her time to the discussion of cases. Her long experience with delinquent girls made her an exceedingly valuable and stimulating advisor. Miss Elizabeth Greene, the organization's psychologist, gave most of the Terman intelligence tests, and contributed valuable observations on the girls' reactions and behavior. The probation officers at the court showed an active interest and were uniformly coöperative. Miss Alice Smith was especially helpful. Her resourcefulness in meeting the many practical difficulties encountered made it possible to conduct the examinations.

A CONTRIBUTION TO THE MENTAL PATHOLOGY OF RACES IN THE UNITED STATES*

PEARCE BAILEY, M.D.

Late Chairman, New York State Commission for Mental Defectives

TO those who believe with Kraepelin that the disposition of a people finds expression in its mental diseases, it would seem that investigations of the mental pathology of peoples and races might lead to some information as to the general characteristics of the peoples concerned. The character and degree of intelligence, emotional stability, morale, and tendencies to criminalism and to inebriety, might be revealed by these measures. Such information might well be more definite than indicated by the actual number of cases found, as for each case pronounced enough to be called a disease there would be many border-line ones of the same category showing the same general trends. An excessive distribution in any community of any particular type of disease might well indicate the general mental level and trend of that community.

Obvious difficulties stand in the way of investigations of this kind. Intensive surveys are necessarily restricted to small groups, and are limited in their general application. General statistics have never been compiled in a manner to throw much light on the subject. The neuropsychiatric statistics of the army, however, afford an opportunity to analyze a large group of all kinds of neuropsychiatric defects and disorders which existed in the representative manhood of the country from 1917 to 1919. It is the purpose of this paper to set forth the results of the analysis of these cases as far as they concern certain foreign-born and native-born races.[1]

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1 The classification of races made use of is taken from the *Dictionary of Races*, prepared under the direction of the Department of Immigration and published in 1910.

From them it appears that, with the exception of epilepsy, certain communities and certain races in the United States display wide variations in the distribution of one or another form of nervous or mental disorders found among them. For example, according to the statistics, the negro exhibits a tendency toward mental defect and away from every other neuropsychiatric condition, while the native-born Scot shows a tendency away from mental defect and toward alcoholism and certain other neuropsychiatric conditions. The widest variations occur in reference to mental defect and inebriety, and the chief value of this study concerns the variations found in respect to these two conditions.

Some races and some communities adhere closely to the median or average. For example, the English show little tendency to vary from the established average. In view of the place the English hold in the world, there is nothing in the present statistics to justify the denial that the middle course, as far as the distribution of nervous and mental disease is concerned, may be the characteristic of the people that attains the most power in the end.

The social value of such information as the statistics yield would, of course, be enhanced by comparison with additional information concerning the circumstances of residence of these races in this country. To draw any final deductions, it would be necessary to know the circumstances of immigration, the causes of emigration, class of immigrants, localities settled in here, and nature of occupations followed.

For example, the statistics indicate that the Italians and Mexicans in the United States are at a low level of intelligence and unable to compete with, let us say, the Scotch or the Irish. But they give no information as to whether these people represent an average of Italians and Mexicans living at home or are merely representatives of inferior groups of Italians and Mexicans who, for some reason or other, have come here.

In comparing the native born with the foreign born, particularly, it would be valuable to know about the circumstances of immigration. The number of foreign-born peoples separately classified is limited, by necessity, to four races: Italian, Scandinavian, Irish, and German. As between them and the

native born of the same race, certain definite variations in the distribution of neuropsychiatric defects are noticeable. For example, practically all native born were found to be more addicted to drugs than the foreign born. Residence in this country seems to foster a drug inebriety or to convert alcoholic inebriety into drug inebriety. Similarly, there appears to be a decrease in the number of cases of insanity among foreigners after residence in this country. Final explanation of these facts, however, must await a fuller knowledge of the circumstances under which a particular group of foreigners came to this country.

Method

The present statistics record only those cases which were identified at recruiting-depot posts and at camps—namely, at the military points of enrollment. They record diagnoses or identifications, irrespective of the military disposition made of the cases. They do not take into account the men rejected by local boards. Thus they cannot determine the percentage of neuropsychiatric cases to the total number of men examined. Information of this character, as far as draftees are concerned, may be obtained in the reports of the provost marshal-general, and in *Defects Found in Drafted Men.*[1] The method used here is that of distribution averages solely. It begins with 69,394 fully classified cases found among volunteers and draftees. (See chart, page 375.) This total of cases was divided into nine distinct clinical groups, and the percentages assigned to each group indicate how that group stood in relation to the total of neuropsychiatric cases found. Thus of all neuropsychiatric cases found in the home forces, black and white, 31.5 per cent were cases of mental deficiency. This percentage represents the distribution average. As such differences existed between white men and negroes, when the distribution average of the United States was determined, it was determined separately for white and colored persons. By this method the average for mental defect in the United States was estimated from the distribution of mental defect among white persons and was found to be 29.2 per cent. A similar

[1] *Defects Found in Drafted Men.* By A. G. Love and C. B. Davenport. Washington: Government Printing Office, 1919.

procedure was followed to determine the variations in the distribution of the various disease types found among the inhabitants of the different states and, as concerns the present article especially, among the members of certain foreign-born and native-born races. The total number of neuropsychiatric conditions found among a people—the Scotch, for example—was ascertained, and the percentage belonging to each clinical group was determined for the Scotch in the same way that it had been determined for the people of the United States as a whole. There was thus furnished a means of comparison between the distribution of each clinical group throughout the United States and the races that were classified. Startling variations were disclosed. This paper was written in the belief that these variations have something to offer toward the understanding of the characteristics of the different peoples concerned.

In interpreting the results, two cautions should be kept in mind: First, as all percentages are based on the total number of neuropsychiatric cases from each race, it is evident that when an excessive percentage is taken up by a single condition, the percentages of the other eight groups must be low—that is, a high rate in one group tends to lower the rate in all other groups.

It also should be noted that in reporting cases the examiners had to choose at times between two or more neuropsychiatric disorders. It is probable that constitutional defects were preferred to alcoholism or drug addiction. But this overlapping is not believed to have affected the rates to any great degree.

Clinical Classification

The chart (page 375) shows the nine clinical groups into which the whole material was divided. It is made up of all cases in which the information was sufficiently detailed to be classifiable, and the figures are only a little under the total number of diagnoses made.

Mental Deficiency.—No idiots reached the military posts, and so this group is made up of imbeciles, morons, those whose disease was on the border lines, and a small number in whom the degree of defect was not determined. About 86 per cent

of all those whose cases were identified were discharged from the service, and as the standard for discharge was fixed approximately at a mental age of eight years, it is assumed that the bulk of the cases were at the eight-year-old level.

Psychoneuroses.—This group is composed of neurasthenia, hysteria, psychasthenia, stammering, enuresis, anxiety neurosis, traumatic cases, and a few scattering and undiagnosed cases.

Psychoses.—In this group are included dementia praecox, manic-depressive insanity, general paresis, and other psychoses associated with syphilis, mental deficiency, and epilepsy.

Nervous Diseases and Injuries.—In this class are grouped the injuries of the nervous system, its organic diseases, and such conditions as tremors, sciatica, ties, etc. Syphilis of the central nervous system was held responsible for 40 per cent of these cases, and consequently a high distribution rate of this group in a people gives some indication of the frequency of syphilis in that people. If to them are added the psychoses due to syphilis (general paresis) and psychoses with cerebral syphilis from the preceding group, the percentage of late nervous syphilis to the total of 69,394 cases would be approximately 3 per cent.

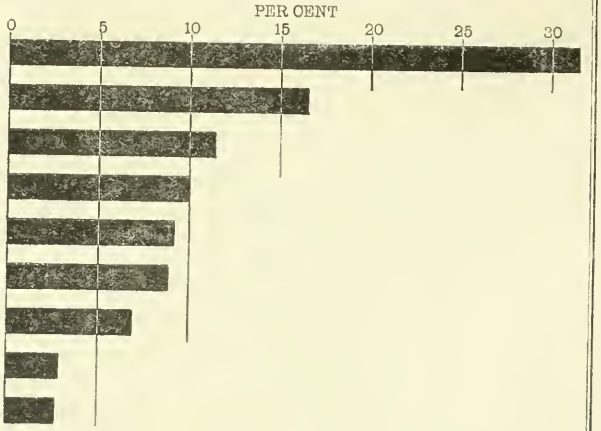
Epilepsy.—This includes both grand and petit mal attacks.

Constitutional Psychopathic States.—This group contains persons socially undependable as determined from personal examination and from past records, classified into those with inadequate personality, emotional instability, paranoid personality, criminalism, sexual psychopathy, and a few other scattering forms. These persons are not feebleminded; on the contrary, they often have active intelligence, thus belonging to the groups of developed intelligence rather than to the mental-deficiency group.

Endocrinopathics.—This group is much larger over the country as a whole than appears from the present statistics because, under the names "effort syndrome", "cardio-vascular" disturbances, etc., many cases fell exclusively to the cardio-vascular examiners. The cases given here include those in which were symptoms of great nervousness, combined with definite lesions referable to the endocrine glands. In 93.7 per cent of the cases the gland at fault was the thyroid.

DISTRIBUTION OF ARMY NEUROPSYCHIATRIC CASES

DIAGNOSES	NUMBER	PER CENT
MENTAL DEFICIENCY	21,858	31.5
PSYCHONEUROSES	11,443	16.5
PSYCHOSES	7,910	11.4
NERVOUS DISEASES AND INJURIES	6,916	10.0
EPILEPSY	6,388	9.2
CONSTITUTIONAL PSYCHOPATHIC STATES	6,196	8.9
ENDOCRINOPATHIES	4,805	6.9
DRUG ADDICTION	2,020	2.9
ALCOHOLISM	1,858	2.7
TOTAL	69,394	100.0



Alcoholism and Drug Addiction.—Alcoholism in these statistics implies a chronic intoxication so profound that the person was, for the most part, beyond reconstruction for military purposes. Drug addiction, while allied to alcoholism as a form of inebriety, is subject to wide variation due to local conditions. It will be observed that the number of drug addicts and of alcoholics is practically the same. It should not be inferred, however, that these two disorders are of equal social importance, for that is far from true. The majority of intemperate men were accepted for service and made good. No medical record was kept of their habits. Records were kept only of the more or less permanently incapacitated alcoholic men. Quite the contrary was true of the drug addicts. They have always been looked on with disfavor by military authorities, and few were retained.

Mental Defect the Pivotal Point

Mental defect, being the most widely distributed condition and the one most directly concerned with the question of general intelligence, becomes naturally the pivotal point of the present discussion. It is assumed to be a distinct clinical entity, classifiable and distinct from insanity or any other of the various neuropsychiatric conditions.

It is the result of a failure of development of the mentality up to a capacity which, as we are dealing only with adults, we may call adult capacity. The normal of adult capacity has been roughly established by psychologic tests among civilized people. It is still unsettled whether or not this standard would be the same for primitive races as for cultured ones—that is, whether or not an average child of a savage, if from infancy it were given the same advantages as, let us say, the average French or English child, would develop into an adult with the average intelligence of a Frenchman or an Englishman. From the statistics which relate to two so-called primitive races—the African and the American Indian—it appears that the primitive could not under any present circumstances attain the average intelligence of cultured races. This appears to be so, not because there is any detailed information as to the potentiality of the primitive mind, but

because mental deficiency is so profusely distributed among Africans and American Indians that their average intelligence must be inferior to that of average European intelligence.

At this point arises a question, and one that cannot be answered from the data on hand: What does excessive mental defect in a race mean? Is it a biologic condition marking the race as being in an early phase of development and establishing a level of intelligence more or less normal for the particular phase of evolutionary development in which the race finds itself, or does it mean that the race has been brought back to a regressive phase through the unrestricted interbreeding of mental defectives? That Caucasian strains can be reduced to low levels of intelligence we know from observation of communities in which the continual interbreeding of mental defectives has brought about that result. Is it possible that in a race we call primitive, like the negro race, a similar thing has occurred, so that the backwardness is the result of some racial setback?

The distribution percentage of mental defect is taken as an index of general intelligence, because when this distribution is excessive, the average intelligence can hardly fail to be lowered. It is lowered not only by the actual mental defectives, but by the number of dull people which the existence of mental defect implies, for it is estimated that for every case of mental defect of the eight-year-old mentality standard, there are at least ten cases of backward or retarded mentality.

An example will make this plain: Vermont[1] showed among its draftees 30.90 mental defectives for every 1,000 men examined. What does this indicate about that community? As mental defect shows no great predilection for either sex, it means that had females been included in the draft restriction, the rate of 30.90 would have been maintained for both sexes in the given age period. As mental defect shows no special predilection for the age period from twenty to thirty, it means that this rate would maintain for the whole population at all ages. It would, therefore, apparently be safe to assume that there are at least thirty defectives per thousand in Vermont of the eight-year-old mentality type, and 300 per 1,000 of

[1] See note, page 372.

TABLE 1. DISTRIBUTION RATES IN NINETEEN STATES IN WHICH THE UNITED STATES MENTAL DEFICIENCY RATE OF 29.2 PER CENT WAS EXCEEDED

STATE	PERCENTAGE OF TOTAL CASES FROM EACH STATE								
	Mental Deficiency	Psychoneuroses	Psychoses	Neurologic Conditions	Constitutional Psychopathic States	Epilepsy	Endocrine Disturbances	Alcoholism	Drug Addiction
United States average..	29.2	17.0	12.1	10.0	9.7	8.6	7.4	3.0	3.0
Alabama	36.0	20.1	11.8	9.9	7.3	9.3	4.0	0.5	1.2
Arkansas	43.7	21.0	9.1	7.2	6.4	8.4	1.4	0.2	2.6
Florida	31.1	18.4	14.5	9.2	8.8	11.2	3.5	0.4	2.9
Georgia	33.3	13.0	13.4	11.5	11.8	7.9	6.1	1.7	2.5
Kentucky	41.1	14.0	6.9	11.8	9.4	8.8	4.2	2.6	1.2
Maine	51.5	13.0	7.7	5.4	8.9	9.2	0.5	2.6	1.3
Maryland	44.9	13.3	10.4	7.6	10.7	4.5	4.4	2.5	1.6
Mississippi	35.4	23.2	9.8	8.3	6.7	10.9	2.1	0.6	3.1
Missouri	33.8	15.9	8.5	11.4	9.4	6.3	8.5	3.3	3.0
New Mexico	61.2	7.0	5.5	7.3	6.1	8.8	3.5	0.6	0.3
North Carolina	46.7	17.7	8.0	6.6	3.9	9.6	6.1	0.6	0.7
North Dakota	38.5	14.1	12.6	9.2	10.3	8.0	3.8	3.1	0.4
Oklahoma	33.3	15.6	11.8	12.7	6.7	6.7	4.0	1.9	7.4
South Carolina	43.4	19.6	7.0	8.2	4.1	8.9	6.1	1.8	1.9
South Dakota	33.1	14.4	10.5	12.8	3.9	6.6	16.1	2.3	0.3
Tennessee	43.0	14.3	9.6	11.9	3.8	8.0	5.1	0.8	3.5
Vermont	33.6	16.8	13.3	10.6	10.6	8.8	3.5	2.7	...
Virginia	45.5	12.0	9.2	7.0	7.4	5.8	10.9	1.0	1.2
West Virginia	38.6	12.6	8.2	9.1	7.8	6.3	15.7	0.7	1.1

TABLE 2. DISTRIBUTION RATES IN FIVE RACES IN WHICH THE UNITED STATES MENTAL DEFICIENCY RATE OF 29.2 PER CENT WAS EXCEEDED

	Number Classified	PERCENTAGE OF TOTAL OF EACH RACE								
		Mental Deficiency	Psychoneuroses	Psychoses	Neurologic Conditions	Constitutional Psychopathic States	Epilepsy	Endocrine Disturbances	Alcoholism	Drug Addiction
United States average	....	29.2	17.0	12.1	10.0	9.7	8.6	7.4	3.0	3.0
African	8,401	48.3	13.1	6.6	9.5	3.0	13.3	3.6	0.3	2.3
American Indian	124	62.9	4.9	4.0	4.0	8.9	7.3	2.4	2.4	3.2
Italian	2,452	32.7	18.1	9.7	7.8	9.3	12.8	3.8	0.4	5.3
Mexican	384	66.9	4.2	4.7	5.7	3.9	11.7	2.3	...	0.5
Slavonic	2,474	37.0	15.3	14.5	7.3	10.0	6.6	5.7	2.5	1.2

backward or retarded persons—persons of distinctly inferior intelligence. In other words, nearly one-third of the whole population of that state is of a type to require some supervision and special educational facilities, and even then they cannot attain the average intelligence of cultured races.

In addition to the lowering of the general intelligence brought about by an overproduction of mental defectives plus the dullards who are always found with them, the outlook for the general intelligence is further impaired by the reduction in the chance of the appearance of persons of superior intelligence with the qualities of leaders.

When countries and especially when races are compared, the significance of a high ratio of distinctly inferior persons in a community becomes apparent. For example, the American Indian presents among his nervous and mental disorders a mental-deficiency-distribution rate of more than double, and the African a rate a little less than double, that of the distribution rate among white persons over the whole United States. This in itself is enough to explain the inability of the two races to compete with the average American. The Mexicans living in the United States present an even higher distribution rate for mental defect (66.9 per cent), but concerning the Mexicans in general—in fact, concerning all races that may have immigrated here within recent years—we can draw no such general conclusions as we can about the indigenous Indian and negro races. Concerning the foreign races that present a high distribution rate for mental defect, such as the Slavs (37 per cent) and the Italians (32.7 per cent), it can only be said that the ones living here now are distinctly below the average United States intelligence. It would be impossible to infer that these races at home present the same degree of mental inferiority; it may be that these countries sent us a high proportion of defectives and that these have intermarried.

Throughout the present material, mental deficiency shows significant correlations with the other neuropsychiatric conditions, and these correlations throw some light on the extent and quality of the intelligence of the people concerned.

As concerns psychoses or mental disorders, it might be assumed that these would be less likely to occur when there was a high rate for mental deficiency. With the exception of the toxic psychoses, the existence of a mental disease implies a developed intelligence, a kind of intelligence that would possess imagination, ideas, a certain quickness in mental processes. As is well known, distinct types of psychoses are

practically unknown in childhood, the period before the intelligence is fully developed. The hypothesis that mental disease implies a developed intelligence and so would be less frequent among people in whom the intelligence is underdeveloped is borne out by the accompanying tables. Nineteen states exceeded the United States mental-deficiency rate of 29.2 per cent, and showed among themselves an average of mental defect of 40.4 per cent. (See Table 1.) But the insanity rate was below the United States rate in these nineteen states, being particularly depressed in the states with high rates for mental defect: Arkansas, Kentucky, Maine, New Mexico, North Carolina, Tennessee, and Virginia. The same correlation holds true for the five races that exceed the United States rate of 29.2 per cent for mental defect (with the exception of the Slavonic)—namely, the Africans, American Indians, Italians, and Mexicans. (See Table 2.)

The converse of this correlation between mental defect and insanity appears in twenty-four states (Table 3) which showed an over-average insanity distribution rate. Of these, North Dakota alone had a high mental-deficiency rate. The same relation holds true for eight of the fifteen classified native-born races which show an excess distribution rate of insanity (Table 6), with the exception of the Slavs. The distribution average of these nine races was 12.3 per cent for psychoses and 21.7 per cent for mental deficiency. An isolated example of the variations between mental deficiency and insanity is shown in the case of Florida. In that state the over-average mental-deficiency rate concerns the white people only—among Florida negroes it was 11.5 per cent, or 17.7 per cent below the United States rate for white people. But the Florida negroes show an insanity rate of 13.8 per cent, which exceeds the United States distribution for insanity in negroes by 7.3 per cent.

Between mental deficiency and alcoholism there seems to exist a very definite antagonism in that the two conditions do not exist in greatest abundance in the same communities and among the same kind of people. When the rate for one rises, the rate for the other falls. Of the nineteen states (Table 1) with an excess of mental deficiency, not one has an excess distribution of alcoholism, and in these nineteen states

TABLE 3. DISTRIBUTION RATES IN TWENTY-FOUR STATES IN WHICH THE UNITED STATES RATE FOR PSYCHOSES OF 12.1 PER CENT WAS EXCEEDED (WHITES)

STATE	PERCENTAGE OF TOTAL CASES FROM EACH STATE								
	Psychoses	Mental Deficiency	Psychoneuroses	Neurologic Conditions	Constitutional Psychopathic States	Epilepsy	Endocrine Disturbances	Alcoholism	Drug Addiction
United States average	12.1	29.2	17.0	10.0	9.7	8.6	7.4	3.0	3.0
Arizona	16.7	15.0	12.5	18.3	11.7	10.9	6.7	4.2	4.2
California	17.4	22.0	16.7	12.2	12.7	7.7	2.7	5.3	3.3
Colorado	14.5	24.8	18.2	10.7	9.5	11.8	6.4	2.1	2.1
Connecticut	15.9	26.7	17.8	7.7	10.3	10.6	3.1	4.9	2.9
Florida	14.5	31.1	18.4	9.2	8.8	11.2	3.5	0.4	2.9
Georgia	13.4	33.3	13.0	11.5	11.8	7.9	6.1	0.7	2.8
Idaho	25.5	26.7	10.3	8.5	6.7	7.9	14.6	...	...
Illinois	13.8	19.9	20.6	10.7	9.1	8.3	9.8	6.2	1.5
Iowa	16.4	25.3	17.8	9.9	9.3	8.4	8.2	2.1	2.6
Massachusetts	14.4	25.7	18.1	6.9	12.2	10.4	1.7	7.9	2.7
Michigan	13.5	29.2	12.0	10.9	11.6	8.6	11.2	2.3	1.1
Minnesota	14.0	22.2	19.5	10.9	7.1	7.8	12.0	4.3	2.2
Montana	20.8	16.7	16.0	11.2	8.9	11.9	7.8	3.0	3.7
Nebraska	15.5	25.1	14.7	12.9	9.4	7.6	10.7	1.6	2.6
Nevada	18.3	18.3	11.7	18.3	6.7	8.3	1.7	15.0	1.7
New Jersey	13.4	27.6	16.6	6.8	11.2	12.6	5.7	3.2	3.0
North Dakota	12.6	38.5	14.1	9.2	10.3	8.0	3.8	3.1	0.4
Oregon	19.7	18.1	19.1	8.9	16.4	9.5	5.3	0.3	2.6
Texas	17.6	25.5	14.8	12.3	8.8	13.4	2.3	1.1	4.1
Utah	18.5	20.5	19.2	6.0	12.6	7.9	4.0	3.3	7.9
Vermont	13.3	33.6	16.8	10.6	10.6	8.8	3.5	2.7	...
Washington	17.7	28.1	14.0	8.2	9.5	7.3	9.3	3.9	6.8
Wisconsin	12.6	27.0	19.2	11.6	6.2	6.8	12.6	3.2	0.7
District of Columbia	19.9	16.1	23.6	14.3	8.7	6.2	6.2	2.5	2.5

the average for alcoholism is 1.6 per cent as compared with 3.0 per cent, the United States average. Conversely, seventeen states exceeded the United States average for alcoholism. A similar antagonism is observed in the various races.

None of the five races (Table 2) that exceed the United States rate for mental deficiency attains the United States alcoholic rate of 3.0 per cent. Conversely, none of the native-born races—the Hebrew, Irish, Scotch, Greek, and Spanish—that exceed the United States alcohol rate attains the United States mental-deficiency rate of 29.2. Similar conditions prevail in the foreign-born races classified.

In the states in which the distribution of mental deficiency is over average, there is practically no change in the rate for epilepsy; in the races a slight increase in the rate for epilepsy occurs. As concerns the psychoneuroses, states and races with plus mental deficiency show a slight decrease. With

some exceptions, constitutionally psychopathic states tended to be below the United States average in both the states and the races that showed an excess of mental deficiency. It would, therefore, seem that an excess of mental deficiency in a people assures an amount of alcoholism, insanity, and psychopathic states below the average, and, conversely, that when these conditions are in excess, mental deficiency recedes.

The foregoing variations apply to the fifteen classified races in the United States as shown in Table 6. Table 4 shows four of them, divided, as was possible, into native born and foreign born.

TABLE 4. DISTRIBUTION RATES OF NEUROPSYCHIATRIC CONDITIONS AMONG FOUR DIFFERENT RACES, WITH COMPARISONS BETWEEN THE NATIVE BORN AND THE FOREIGN BORN

RACE	PERCENTAGE OF TOTAL OF EACH RACIAL GROUP									
	Number Classified	Mental Deficiency	Psychoneuroses	Psychoses	Neurologic Conditions	Constitutional Psychopathic States	Epilepsy	Endocrine Disturbances	Alcoholism	Drug Addiction
United States average	...	29.2	17.0	12.1	10.0	9.7	8.6	7.4	3.0	3.0
Italian:										
Native born	413	33.9	13.6	11.6	6.5	10.9	2.2	1.0	1.2	19.1
Foreign born	2,039	32.5	19.0	9.3	8.0	9.0	15.0	4.4	0.2	2.6
Scandinavian:										
Native born	890	26.7	17.8	15.4	9.1	8.3	6.6	11.0	2.8	2.1
Foreign born	366	15.8	16.9	21.9	12.6	8.5	7.1	9.3	6.6	1.4
Irish:										
Native born	4,068	21.6	14.7	10.9	11.6	11.6	8.2	6.6	9.4	5.4
Foreign born	394	15.0	15.7	20.1	10.9	6.6	7.9	4.8	18.0	1.0
German:										
Native born	4,164	28.1	17.6	12.3	9.6	10.1	7.3	11.0	2.4	1.6
Foreign born	187	25.7	15.5	21.4	10.7	7.0	8.6	7.5	2.1	1.6

MENTAL CONDITION OF VARIOUS RACES IN THE UNITED STATES

African Race.—(Number classified, 8,401.) The most striking characteristic of the negro is the wide distribution of mental defect (48.3 per cent) and the low distribution of alcoholism. In negroes the mental-deficiency rate exceeded the United States rate for white people by 19.1. The Southern states are high in mental defect, but the negro cannot be held entirely responsible for this as in many Southern states the

mental defect for white people exceeds that for negroes, as shown in Table 5.[1]

It will be observed that in these Southern states the average mental-deficiency rate for the white population is considerably higher than the United States average for white people—29.2 per cent—and that the average rate for the negro is considerably below the United States average for the negro—48.3 per cent. In Florida, Georgia, Kentucky, North and South Carolina, and West Virginia there are proportionately more white than colored mental defectives.

TABLE 5.—Mental Deficiency Distribution Rates for White and for Black Population in Twelve Southern States

	Negroes	Whites
United States average	48.3	29.2
Alabama	66.4	36.0
Florida	11.5	31.1
Georgia	31.7	33.3
Kentucky	38.5	41.1
Louisiana	48.3	28.7
Mississippi	44.6	35.4
North Carolina	40.8	46.7
South Carolina	40.0	43.4
Tennessee	71.8	43.0
Texas	33.4	25.5
Virginia	48.6	45.5
West Virginia	37.5	38.6

Some students seem to think that the backward condition of the negro is the result of his environmental conditions—that if he were given opportunity he could approximate the Caucasian standard of mentality. The present statistics do not bear out such an opinion.[2]

It is true that in certain Northern states the mental-defici-

[1] No cases of mental defect among negroes, or too few to classify, were found in California, North Dakota, South Dakota, Oregon, Utah, Vermont, Washington, and Wyoming. This simply means a small negro population, as these states together gave a total of forty-five psychiatric cases among the negroes.

[2] According to Trabue, intelligence rating taken of drafted negroes from Louisiana and Mississippi, and of white men from Illinois, Wisconsin, and Minnesota, showed that only 0.2 per cent of the negroes from Louisiana and 0.5 per cent of the negroes from Mississippi were graded as superior, while 10.7 per cent of the white men had this standing. At the other extreme, only 7.4 per cent of the white men had a grade of inferior or very inferior, while 52.9 per cent of the Mississippi negroes, and 63.3 per cent of the Louisiana negroes, had this low grade.

ency rate for negroes is much lower than in the South—indeed, in New Jersey it is lower for negroes (21 per cent) than for white people (27.5 per cent). The apprentice system for slaves prevailed in New Jersey until 1863. This system provided supervision and care and may help to explain the present superior quality of negroes in New Jersey. Also, one must bear in mind that mental defect is a social weed, tending to spread. One must also bear in mind the important factor of migration. The brighter and more enterprising members of rural communities have for years been pushing out for the large cities, leaving the dullards and defectives on the plantations and farms. It seems, therefore, possible that the higher mentality of Northern negroes is not the result of environmental conditions, but is due to the fact that they came of better stock in the first place, the Northern negro population consisting of slaves who had had wit enough to escape or servants selected with greater care—that the low mentality of the Southern negroes is due to their staying together and interbreeding.

In contrast to the high distribution of mental deficiency among the neuropsychiatric conditions of negroes, alcoholism among them practically did not exist. There were only twenty-nine cases in all. This absence of the disastrous effects of intemperance contradicts the current belief that the ravages that result from the abuse of alcohol are particularly severe among primitive races. Data relative to the use of alcohol show that 13 per cent of the white and 10 per cent of the colored neuropsychiatric cases had a record of intemperance. It would seem, therefore, that the negro can be practically as intemperate as the white man without paying the same penalty for it. On the other hand, he is much more susceptible to venereal diseases; 57.8 per cent of all negroes gave a history of venereal infections of some sort, while only 22.3 per cent of white people gave such a history. In view of this great disparity, and since the white people actually drank more than the negroes, it would seem that some modification would have to be made in our views of the prime importance of alcohol as a factor in the spread of venereal diseases.

A similar, though less marked, resistance to the involvement of the central nervous system by syphilis is shown by

the negro. Among neuropsychiatric cases the history of preceding syphilis was more than three times as frequent in negroes as in white persons, but the involvement of the central nervous system by that disease was about equal in the two classes.

TABLE 6. DISTRIBUTION RATES OF NEUROPSYCHIATRIC CASES AMONG FIFTEEN CLASSIFIED RACES

RACE	PERCENTAGE OF TOTAL OF EACH RACE									
	Number Classified	Mental Deficiency	Psychoneuroses	Psychoses	Neurologic Conditions	Constitutional Psychopathic States	Epilepsy	Endocrine Disturbances	Alcoholism	Drug Addiction
United States average	...	29.2	17.0	12.1	10.0	9.7	8.6	7.4	3.0	3.0
African	8,401	48.3	13.1	6.6	9.5	3.0	13.3	3.6	0.3	2.3
American Indian	124	62.9	4.9	4.0	4.0	8.9	7.3	2.4	2.4	3.2
Dutch	328	26.2	14.9	13.1	11.6	10.1	10.4	10.4	1.8	1.5
English	9,092	29.2	16.5	11.8	10.0	10.7	8.9	8.8	2.2	1.9
French	941	29.1	18.5	10.1	10.8	8.0	10.8	5.8	4.1	2.7
German	4,351	28.0	17.5	12.7	9.6	9.9	7.4	10.9	2.4	1.6
Greek	281	23.8	24.9	13.9	8.9	8.2	13.5	5.3	1.1	0.4
Hebrew	1,314	17.2	25.2	14.9	7.5	15.4	7.1	5.6	0.5	6.7
Irish	4,462	21.0	14.8	11.7	11.6	11.1	8.2	6.4	10.1	5.0
Italian	2,452	32.7	18.1	9.7	7.8	9.3	12.8	3.8	0.4	5.3
Mexican	384	66.9	4.2	4.7	5.7	3.9	11.7	2.3	...	0.5
Mixed	23,604	27.5	18.4	12.2	10.2	9.9	8.7	7.2	2.3	3.7
Scandinavian	1,256	23.6	17.5	17.3	10.1	8.4	6.8	10.5	3.9	1.9
Scotch	579	12.4	18.3	12.3	16.6	10.7	9.3	10.4	5.4	4.7
Slavonic	2,474	37.0	15.3	14.4	7.3	10.0	6.6	5.7	2.5	1.2

The correlation of mental deficiency with other neuropsychiatric conditions gives important information both as to mental deficiency in relation to the United States average for white persons and in relation to its average distribution among the negroes exclusively.

Of the first, Table 6 shows that, with the exception of mental deficiency and epilepsy, the negro falls below the United States average for all neuropsychiatric conditions. The negro falls much farther below both white and negro average for all these conditions in seven states in which he exceeds the negro United States rate for mental defectives. An undue distribution of mental defect inevitably necessitates a falling off in other neuropsychiatric conditions; but, as stated before, when mental defect is above the average, the falling off affects especially mental diseases, constitutional psychopathic states, and inebriety.

The provost marshal-general, in his final report, credits the negro draftee with a somewhat better physique than the white. The present statistics bear this out as far as the two neuropsychiatric conditions that have a definite physical basis are concerned—namely, neurologic conditions and endocrine disturbances. The particular distribution of neuropsychiatric defects among negroes points them out clearly as a primitive race. Physically, they may be above the average of the people with whom they associate, but they are far below that average in mental capacity.

It will hardly be possible to determine what better social opportunities and education will do for negroes before the present high incidence of mental defect among them is reduced.

American Indian.—(Number classified, 124.) The American Indian—or Amerindian, as H. G. Wells calls him—is primitive like the negro, and exceeds even him in mental deficiency. He is not as much below the United States average in alcoholism or drugs as the negro, and is somewhat below the negro in epilepsy, as indeed he is below the United States average in that disease. In other conditions—namely, neurologic, psychoses, psychoneuroses, endocrine and constitutional psychopathic states—he is far below the United States average. His high mental-deficiency percentage leaves little room for anything else. The small number of American Indians classified should be borne in mind when these statistics are considered.

Dutch.—(Number classified, 328.) The Dutch are close to the United States average in all groups. The indications are that they ingest more alcohol than drugs, but in both they fall below the United States averages. They have a few less neuroses and a few more of the other classified disorders.

English.—(Number classified, 9,092.) The English, like the Dutch, approximate the United States average in all groups. They appear more inclined to drink than to take drugs, and to have a slight excess of epilepsy, endocrine troubles, and constitutional psychopathic states. They just reach the United States average for mental defect.

French.—(Number classified, 941.) The French show rather a high distribution of inebriety, being considerably above the

average in alcoholism and only a little below it in drug addiction, their total percentage of inebriety distribution being 6.8 per cent as compared with 4.1 per cent for the English, and 4.0 per cent for the Germans. They also exceed the average in the relative number of cases of psychoneuroses, neurologic conditions, and epilepsy. They are considerably below the average in endocrine disease and are at the United States average for mental defect. The excess of inebriety in the French may surprise many, as the French are said to be a wine-drinking people and it is a common belief that wine-drinking people do not suffer from alcoholism. As a matter of fact, alcoholism depends on the actual amount of alcohol imbibed, rather than on the form in which it is taken. If enough wine or beer or any other beverage with comparatively low alcohol content is taken, a person becomes alcoholic. As far as France is concerned, large quantities of spirits are consumed in that country in addition to wines, and it may be that this custom persists among the French who live in this country.

The Native-Born German.—(Number classified, 4,164.) In spite of his reputed beer-drinking custom, the native-born German, according to the statistics, fails to reach the United States average in alcoholism and is not much given to drugs. On the other hand, he exceeds slightly the United States average in psychoses, neuroses, and constitutional psychopathic states, and in endocrine diseases by 3.5 per cent. He is slightly below the United States average in mental defect.

The Foreign-Born German.—(Number classified, 187.) The foreign-born German shows a much higher rate for insanity than the native born, but a considerably lower rate in endocrine diseases. Mental defect also is considerably less prominent.

Greeks.—(Number classified, 281.) The Greeks are very low in inebriety, especially as concerns drugs, but exceed the United States average in epilepsy, psychoses, and psychoneuroses, an excess particularly noticeable in epilepsy and psychoneuroses. They are well below the average in mental defect and constitutional psychopathic states.

Jews.—(Number classified, 1,314.) The American Jew shows a striking contrast in his habits of inebriety as far as

the choice of alcohol and drugs is concerned. The number of Hebrew alcoholic patients is almost negligible, while the percentage of drug addicts is more than double the United States rate. The percentage of neurologic conditions, epilepsy, endocrine diseases, and mental deficiency among Jews is also low. The low percentage of mental defect is particularly striking, the only classified races that show less being the Scotch and the Welsh. The Jew exceeds, on the other hand, the average representation in the conditions characterized by emotional instability. The percentage of insanity among Jews is nearly 2 per cent above the United States average and is very much above it for psychoneuroses and the constitutional psychopathic states.

Native-Born Irish.—(Number classified, 4,068.) The native-born Irish show the most pronounced tendency to inebriety of any neuropsychiatric group except the foreign-born Irish, and their intemperance relates to both alcohol and drugs. Inebriety constitutes 14.8 per cent of all their neuropsychiatric disorders. Approximately one-sixteenth of all the neuropsychiatric cases being found among the Irish, more than one-fifth of all patients with alcoholism were identified as Irish by the neuropsychiatric examiners and more than one-sixth of all patients with drug addiction. With the exception of inebriety, epilepsy, and constitutional psychopathic states, they sink below all United States averages. They are so far below this average in mental defect that they confirm the general law of the incompatibility of alcoholism and mental defect. They also furnish an interesting example of a high distribution of alcoholism with an under-average of mental disease. It would seem that if alcoholism were an important cause of insanity, one would find an excess of insanity instead of an under-average in a people so given to alcoholic intemperance as these people are. But in this connection it should be remembered that drafted men were too young to develop alcoholic insanity and also that alcoholic insanity among the Irish is more common in women than in men.

The Irish offer an interesting comparison with the English. There are 11.0 per cent more cases of inebriety among the Irish and 8.2 per cent less cases of mental defect. The

excess of alcoholism and the lesser amount of mental defect would indicate that they are a livelier, more excitable race than the English, which is borne out by their having a slight excess of constitutional psychopaths as compared with the English.

Foreign-Born Irish.—(Number classified, 394.) The difference between the native-born and foreign-born Irish in regard to nervous and mental diseases is that among those born in this country the distribution rate of mental defect is nearly 7 per cent more than among the foreign born, and among them also there is a higher distribution rate of constitutional psychopathic states and of endocrine disturbances. The average for insanity and inebriety, however, is lower. These are 9.2 per cent less in the distribution of mental disease among those born here. Inebriety changes both in extent and in its own distribution. There is a lessened total of inebriety of 4.2 per cent among the native born, and even a greater falling off in the distribution rate of alcoholism. About one-half of the decrease in alcoholism is accounted for by an increase in drug addiction among the native born. It would seem at first sight that this lowering of the distribution rate for insanity is to be connected with the lowering of the rate of alcoholism, but it should be observed that a similar decrease in the distribution of insanity occurs in the Germans, with a very minor decrease in alcoholism, and a smaller decrease in insanity among Scandinavians, with a larger decrease in the rate of alcoholism.

Also, as far as the Irish are concerned, the material increase in mental defect and in constitutional psychopathic states should be noted.

Native-Born Italians.—(Number classified, 413.) The native-born Italians present a distribution of neuropsychiatric disorders which indicate a sluggish, backward mentality. As drug addicts they rank higher than the Jews, and, like the Jews, are little given to alcoholic inebriety. Some races, such as the Jewish and the Irish, seem to be able to surpass the average in drug inebriety, and still, through the low percentage of other disorders that indicate racial backwardness, retain the characteristics of nimble-minded people. For example, the Irish, while they are excessive drug users, are

more given to intemperance in alcohol than in drugs; and of the two, alcoholic intemperance is indicative of more active mentality than is the secret and solitary use of drugs. Both the Irish and Jews, while exceeding the average in the use of drugs, are far below it in mental defect. But the Italians make the poorer choice for the satisfaction of their inebriate tendencies, and in addition to that, show their racial backwardness by a preponderance of those other disorders which must be accepted as indicative of inferiority. In mental defect the native-born Italians exceed the United States average by 4.7 per cent.

Foreign-Born Italians.—(Number classified, 2,039). The foreign-born Italian shows such considerable variation from the native born in the distribution of neuropsychiatric disorders that it seems that being brought up in this country has marked effect on him in this respect. The rate of epilepsy is much higher among the foreign born, but drug addiction is notably more frequent among the native born, as in fact it is among all the native-born foreign races except the German.

Mexicans.—(Number classified, 384). Of all races classified, the Mexican stands first in mental defect, the rate being 66.9 per cent. It exceeds that of the Africans and Amerindians. With the single exception of epilepsy, they are below the United States average in every other neuropsychiatric group. They seem to be swamped in their own dullness, and they cannot develop, to any great extent, any of the disorders that indicate an active or emotional intelligence. There was not a single alcoholic person among those examined and only two drug addicts, as contrasted with 45 epileptic patients and 257 mentally defective. One would hardly expect that a race so slothful as the enormous amount of mental defect found among them makes the Mexicans appear to be would be a drinking people. But it is rather surprising that they are free from drug addiction. Mexico is said to be one of the points from which opium (and its derivatives) is smuggled into this country, and one would naturally think that the Mexicans themselves would become addicted to the use of it.

The Mixed Races.—(Number classified, 23,604.) The mixed races include those whose ancestors were of different races. This group, of course, includes many "Americans". The

large number in it (one-third of the total number of cases) makes this group fundamentally important in the establishment of the United States average.

Native-Born Scandinavians.—(Number classified, 890.) Native-born Scandinavians (Norwegians, Danes, Swedes, Icelanders) show an excess of psychoneuroses, psychoses, and endocrine disorders. They are well below the average in mental defect and, almost as a corollary of this, in epilepsy.

Foreign-Born Scandinavians.—(Number classified, 366.) The foreign-born Scandinavians show much less mental deficiency than those born here, and, strangely enough, less endocrine disturbance. On the other hand, they show an excess distribution of alcoholism and insanity as compared with the native born.

The Scotch.—(Number classified, 579.) The Scotch exceed the United States average in all groups except that of mental deficiency. The mental-deficiency rate—16.8 per cent—is lower than that of any race, being below the United States average. This bears out the reputation of the Scotch for intellectual superiority. The inebriety is high, but as in all races that have a low mental-deficiency rate, alcoholism exceeds drug taking.

The Slavs.—(Bohemians, Bosnians, Croatians, Dalmatians, Herzegovinians, Montenegrins, Moravians, Poles, Russians, Ruthenians, Serbians, Slovaks, and Slovenians. Number classified, 2,474.) The Slavs have a high mental-deficiency rate, in spite of which their inebriety is alcoholic rather than narcotic, although both varieties are below the United States average. The comparative infrequency of epilepsy is worthy of remark, especially in view of the high rate of mental deficiency. In spite also of the sluggishness indicated by the excess of mental deficiency, they have an emotional sphere of some activity, as is shown by the excess of psychoses among them.

DR. PEARCE BAILEY

AT the age of fifty (1915) Pearce Bailey had made for himself an eminent place in medicine and neurology. A graduate of Princeton (1886) and in medicine of Columbia University (1889), he had later studied abroad, mostly in France, and had returned to enter the field of neurology. His early interest was in neuropathology and organic neurology, but he became interested in the traumatic neuroses and in 1898 had published *Accident and Injury; Their Relation to Disease of the Nervous System.* He was adjunct professor of neurology at Columbia from 1906 to 1910; consulting neurologist at St. Luke's, Roosevelt, New York, Orthopedic, Manhattan State, and St. John's Hospitals. He had served as president of the American Neurological Association during 1913 and as president of the New York Neurological Society from 1903 to 1905. He was a member of the American Medical Association, the American Psychiatric Association, the New York Pathological Society, and the New York Academy of Medicine. He had been one of the founders of the New York Neurological Institute and had served as chief of one of the sections.

It is interesting to note, however, that it was after 1915 that Dr. Bailey undertook and carried through the three undertakings that probably most distinguished his professional career—the organization of the Division of Neurology and Psychiatry in the Office of the Surgeon General, Washington, 1917, the chairmanship of the New York State Commission on Mental Defectives, 1919, and the organization of the Classification Clinic, 1920.

When it became certain that the United States would enter the World War, Dr. Bailey was one of those physicians who saw the importance of creating an army that would be nervously and mentally as well as physically fit. Previous to the declaration of war, Dr. Bailey, with Dr. Stewart Paton and Dr. Thomas W. Salmon, had been requested by the Surgeon General of the Army to make a trip of inspection to

the Mexican Border, where troops were then mobilized to study the facilities in the army for the treatment of nervous and mental patients. The facilities were found not to be adequate, and the Surgeon General requested The National Committee for Mental Hygiene to draw up proper plans for this branch of the army medical work and to organize neuropsychiatric units for the military hospitals. A special committee, known as the Committee to Furnish Neuropsychiatric Units to Base and Other Military Hospitals, and later as the War Work Committee, was appointed by the president of the National Committee, and Dr. Bailey was asked to serve as its chairman. Under his chairmanship, plans, including equipment, for special neuropsychiatric wards in base and general hospitals were prepared; methods for the neuropsychiatric examination of the army personnel, for the purpose of eliminating those nervously and mentally unfit, were drawn up; the preparation of special army psychological tests was assisted; a personnel of psychiatrists and neurologists was recruited, including a specially trained nursing and attendant personnel; and five graduate schools of neuropsychiatry were organized for the further training of medical officers.

At the request of the Surgeon General, Dr. Bailey accepted a commission as major in the medical corps of the army, and in July, 1917, reported in Washington to organize in the Office of the Surgeon General the Division of Neurology, Psychiatry, and Psychology. (The Psychological Section was later made an independent division.) Promotion to lieutenant colonel and to colonel followed. He served as chief of the new division until his discharge in February, 1919. In 1918 he spent three months in France on a trip of inspection. The most outstanding achievement of his work as Chief of the Division of Neurology and Psychiatry, aside from the successful carrying through of the plans already indicated, was the incorporation of the post of division psychiatrist in the tables of organization of the army. The creation of this post was of the greatest significance in that it assured to each army division a psychiatric chief who was responsible for the mental and nervous health of the men in his division: while in the United States, the elimination of the unfit was under his supervision,

and in the A. E. F. the organization of facilities for the immediate treatment of those who developed neuroses. For his services during the war, Dr. Bailey was granted a Distinguished Service Medal.

On completing his work in the army, Dr. Bailey was invited by the Governor of New York to accept the chairmanship of the State Commission on Mental Defectives. Long familiar with the clinical aspects of mental deficiency, Dr. Bailey had become, while in the army, impressed with the importance of mental deficiency as a social problem. He accepted the chairmanship. With his usual perspicacity, he saw his problem as a series of problems, and while attempting to coördinate them all, selected those that to him seemed of most immediate importance and with his quiet energy set about to solve them. In his thinking he at once separated the non-delinquent from the delinquent mental defective. For the former, he encouraged special education, either in ungraded classes of the public schools or in institutions, and supervision in the community after completion of the school work. He was particularly interested in the possibilities of supervised colonies from the state schools for the mentally defective. For the latter—the delinquent mental defectives—he created at Napanoch a special institution, the first institution for defective delinquents in this country.

Dr. Bailey had long been interested in the problem of the "different" or "odd" child, and particularly the problems of such children as they pass through adolescence. Although facilities exist for the care and training of the defective child and of the child who is definitely ill, either of physical or nervous disease, but little attention has been given to the supposedly "normal" child who is merely queer or difficult; he has rather been supposed to outgrow these difficulties and to take his place and compete with his fellows. Dr. Bailey's clinical experience had made him less sanguine of the later success of these children, and he believed that the nervous illnesses from which they came to suffer in their effort to adjust themselves in an adult world, or the mediocrity and lowered social efficiency into which they slipped, could in part be prevented by a proper study and understanding and ad-

justment of the child during its adolescence. To this end, therefore, he established in 1920, in connection with the Neurological Institute, a clinic of very great possibilities, which he chose to call the Classification Clinic.

Dr. Bailey was a director of The National Committee for Mental Hygiene and from the beginning contributed regularly to MENTAL HYGIENE. His last paper, *State Care, Training, and Education of Mental Defectives,* appeared in MENTAL HYGIENE the week of his death. In this number is reprinted, through the courtesy of the editor of the *Archives of Neurology and Psychiatry,* of whose editorial board he was a member, *A Contribution to the Mental Pathology of Races in the United States.* This article was published in the *Archives* for January and is the last of a series of papers Dr. Bailey published on the data collected during the war by the Division of Neurology and Psychiatry. Other important papers contributed to MENTAL HYGIENE are: *Efficiency and Inefficiency; a Problem in Medicine* (April, 1917); *Care and Disposition of the Military Insane* (July, 1918); *Care of Disabled Returned Soldiers* (July, 1917); *Applicability of the Findings of the Neuropsychiatric Examinations in the Army to Civil Problems* (April, 1920); *Mental Deficiency: Its Frequency and Characteristics in the United States as Determined by the Examination of Recruits* (July, 1920).

While Dr. Bailey chose to devote his professional life to neurology and psychiatry, he was not a specialist of narrow interests. His interests were broad and essentially "human". The early death of his wife and illness in his family tinged his own life with sorrows, but he never lost sight of the sorrows of his fellow-men, nor did he falter in his effort in their behalf. His work will live after him, like something that grows.

ABSTRACTS

MENTAL DISEASE IN CITIES, VILLAGES, AND RURAL DISTRICTS OF NEW YORK STATE, 1915-1920. By Horatio M. Pollock, Ph.D., and William J. Nolan. *State Hospital Quarterly*, 7:38-65, November, 1921.

The most striking contrast in environment in the state is that of New York City with the rest of the state. New York City is in a class by itself. Its population is composed of many diverse elements and new elements are constantly being added. It has the extremes of wealth and poverty and of luxury and wretchedness. The density of its population in some sections greatly exceeds that found in any other city of the state. Its crowded tenements, streets, subways, and elevated roads, with their many discordant noises, and the rush and whirl of business and pleasure demand adaptations on the part of the individual to a far greater degree than the relatively quiet environment of the smaller cities and other communities of the state.

We should expect, therefore, that the rate of incidence of mental disease in New York City, as shown by the first admissions to the civil state hospitals, would vary considerably from the rate in other parts of the state.

Table 1. Rates of Mental Disease in New York City and Other Parts of the State Compared, 1915-1920

PSYCHOSES	First admissions from New York City		First admissions from other parts of the state	
	Number	Average annual rate per 100,000	Number	Average annual rate per 100,000
Senile	1,605	6.0	1,526	6.5
Cerebral arteriosclerosis	1,026	3.8	1,004	4.3
General paralysis	2,839	10.6	1,415	6.0
Cerebral syphilis	107	0.4	103	0.4
Alcoholic	949	3.6	713	3.0
With other somatic diseases	562	2.1	402	1.7
Manic-depressive	2,861	10.7	1,548	6.6
Involution melancholia	356	1.3	774	3.3
Dementia praecox	5,607	21.0	2,911	12.4
Paranoia or paranoid conditions	257	1.0	372	1.6
Epileptic	456	1.7	302	1.3
With psychopathic personality	354	1.3	314	1.3
With mental deficiency	432	1.6	472	2.0
All other psychoses	1,795	6.7	1,293	5.5
Total	19,206	72.0	13,149	56.0

The trend of population from country to city has wrought many other changes in the population of the state during the past three decades. In 1920, 82.7 per cent of the population lived in urban environment—i. e., in cities and villages of 2,500 inhabitants or more. In 1890 the percentage living in urban environment was only 65.

Table 2. Rates of Mental Disease in Urban and Rural Districts, 1915-1920

Psychoses	Urban first admissions		Rural first admissions	
	Number	Average annual rate per 100,000	Number	Average annual rate per 100,000
Senile	2,535	6.2	596	6.4
Cerebral arteriosclerosis	1,698	4.2	332	3.5
General paralysis	3,987	9.8	267	2.9
Cerebral syphilis	186	0.5	24	0.3
Alcoholic	1,510	3.7	152	1.6
With other somatic diseases	839	2.1	125	1.3
Manic-depressive	3,839	9.4	570	6.1
Involution melancholia	855	2.1	275	2.9
Dementia praecox	7,790	19.1	728	7.8
Paranoia or paranoid conditions	535	1.3	94	1.0
Epileptic	652	1.6	106	1.1
With psychopathic personality	558	1.4	110	1.2
With mental deficiency	702	1.7	202	2.2
All other psychoses	2,696	6.6	392	4.2
Total	28,382	69.5	3,973	42.5

Before the days of accurate statistics, it was frequently stated that there was a higher rate of mental diseases in rural districts than in cities, but judging from present well-established facts, the statement was never true. From the accompanying table (Table 2) it will be seen that in certain minor groups the rate of incidence is higher in rural than in urban districts, but the general rate in rural districts is much lower.

Of the 32,355 first admissions, 28,382, or 87.7 per cent, came from urban districts, and 3,973, or 12.3 per cent, from rural districts. The rates per 100,000 of the same environment were 69.5 and 42.5 respectively. General paralysis, alcoholic psychoses, and dementia praecox are predominantly city diseases. These, with manic-depressive psychoses, comprised 60.4 per cent of the cases from urban districts, but only 44.7 per cent of those from rural districts.

A Habit Training School for the Mentally Deteriorated. By Charles F. Read, M.D. *The Modern Hospital*, 18:135-38, February, 1922.

The regression to an extremely low level of behavior that is a characteristic symptom of dementia praecox was for a long time accepted as a necessary evil. "It was well known that spontaneous improvement took place at times in certain patients and that industry in general prompted habits of cleanliness, but little organized effort was made to produce this result upon a large scale as a part of a program for the betterment of this class of patients. Only within the last few years have the so-called 'untidy wards' of dementia-praecox cases been looked upon as an institutional reproach and the habit training of this group of regressives systematically undertaken.

"Illinois has been one of the first states to establish a state-wide program of occupational therapy, and as a part of this program at the Chicago State Hospital two wards for women, with a capacity of about 35 each, are set aside for habit training. They are structurally unsuitable, but are the best to be obtained. In like manner two larger wards of better construction are used for the male pupils. Upon one ward in each group are placed the more promising of the untidy praecox cases; very old cases and cases impulsively violent are excluded. The other ward serves as a promotional one for improved cases. To these wards are detailed intelligent attendants in charge of women of experience and sympathy.

"The following program, while elastic, outlines briefly the essentials of this work. It is not sufficient to direct the ward assistants in a general way to see to it that their patients are properly bathed, dressed, specialed, etc. They must be given certain things to do at certain definite times and required to carry these things out to the letter with the understanding that this effort, while necessarily routine in character, actually represents the early development of a movement away from the old-time hospital routine.

Daily Program in Habit Training Wards

6:00	Rising bell. Special, wash, brush teeth, comb hair, lace shoes, dress, air beds.
7:00– 7:30	Breakfast. Care of the wards for those who are able, make beds, sweep floors, etc.
9:00–10:00	Give water, special, care for nails, prepare for class.
10:00–11:00	Class work: kindergarten and other simple occupations.
11:30–11:45	Put up work and clean up.
11:45–12:00	Prepare for dinner, special, wash, etc.
12:00–12:30	Dinner.

12:30– 1:15 Care of teeth, special.
1:15– 2:30 Story telling and blackboard work.
2:30– 3:00 Give water, special, tidy up for exercises.
3:00– 4:30 Gym work on lawn if possible, if not in gymnasium. (Exercises should be simple and varied.) Walk.
4:30– 5:30 Special, rest, and make tidy for supper.
5:30– 6:00 Supper.
6:00– 8:00 Music. Patients dance on ward: their minds to be kept as pleasantly occupied as possible.
8:00 All to toilet, wash teeth, brush hair, put to bed with night gowns.
10:00–12:00–2:30–4:30 Night specialing.

"Here, as in the case of all 'programs', everything depends upon the spirit with which a difficult task is approached. The chief nurse, the occupational aid in charge of occupational therapy upon the ward, and the attendants must all be full of confidence that the object in view can be attained in spite of many discouragements. It is easy to write such a program, but no one who has not seen it put into practice can realize the pertinacity required for carrying it out successfully; not only pertinacity, but much sympathy and a faith that finds its justification in its works.

"Upon the other hand, when we remember that we are not dealing with the feebleminded, although these people behave in many ways like children, it can be more readily understood that this training in the individual case does not always progress in plodding fashion. These patients, as before stated, possess habit patterns that have not been destroyed, but have merely fallen into disuse. It is, therefore, not unusual to see a canalization occur quite speedily and the untidy patient become rapidly, almost suddenly, clean and interested in the work of the ward and in the special outlets for interest afforded by occupational therapy. These are the bright spots, the high lights in this work. Upon the other hand, there are patients that would test the patience of Job. There are some who never improve or improve only to backslide. Not all recover or improve sufficiently to go home, but considerable numbers do, as a result of training, attain to a higher level of living which makes it possible for them to lead a more comfortable, useful life, even though this life may remain institutional in character. Even from this latter viewpoint, it can readily be seen that this work is a benefit to the state as well as to the patient, since whatever benefits the individual cannot but realize a public gain. The patient who formerly required incessant care and rendered no service ceases to become in time an institutional problem and may even develop into a positive asset as an industrial worker. . . .

"At Kankakee 106 patients have passed through the habit training ward during the past year. Six were paroled home directly from the cottage, 5 more went home after being promoted to better wards. Twenty-two patients failed to show results and were finally demoted. Most of these were women who had been in the institution for more than fifteen years. A few were younger cases who seemed to be incapable of improvement. *Eighty-four were advanced to better wards* where they still are subject to some supervision as to personal habits and where they are occupied during the day. The class building at Kankakee is a singularly pleasant little cottage, skillfully remodeled for this purpose. Unfortunately no intensive work has been carried on with the male patients as yet.

"During this same period at Chicago State Hospital 196 patients were treated in the female habit-training wards and 87 were improved, 10 going home. Good results were also obtained upon the male wards, though not so striking, because they were not so well organized. For obvious reasons, it is more difficult to carry out this work with men than with women and its thorough development comes later.

"Now a word as to the *ideal* arrangement for such work. There should be at least two wards for each sex, preferably cottages of bungalow construction, one for the beginners and another for those promoted. The day room should be large, light, and airy, with drinking fountain, wash bowl, and mirror in the room so that all the patients may be benefited by observing those who make use of these facilities. The dormitory should not be crowded. There should be no single rooms, because all these patients are pretty much on the same level *and the endeavor to train them is a group proposition.* The toilets and bathroom should be separate. In the toilet the seats should be separated by partitions to give some degree of privacy and thus foster a return of the proper conventions. Lavatories must be generously supplied. The clothes room should be large and adequately supplied, not only with hooks for underwear and dresses, but with hangers for outside wraps, hats, etc. Much can be accomplished, especially with women, by appealing to their dormant desire to appear well. There must be a dining room upon the ward and the tables should be small, seating groups not larger than six each, preferably four. *There must be no crowding anywhere.* The paint should be attractive, even gay, in color, to which other decorations of one kind or another should be added, such as wall-paper panels, pictures, attractive hangings, rugs, plants, in fact everything that can be assembled to appeal in a well-bred manner to the patients' dormant love for color. There should be a phonograph in the day room with records that are fresh and often changed. There is nothing worse

for a patient than the constant use of old, cracked records. Animal pets or canaries should be allowed them if possible.

"The foregoing description applies to the male wards as well as the female wards. Both sexes should be supplied with non-institutional clothing in so far as possible. Strong dresses, drab-colored dresses, blue jeans, etc., are to be avoided. The extra care given should do away with the necessity of these familiar institutional garments.

"Upon the promotional wards there should be some more advanced occupation of a therapeutic character, such as wood sawing and sand papering for the men, doll making and simple forms of sewing or weaving for the women. These occupations, together with the necessary housekeeping that is always to be done, accord a considerable variety of outlets for the patients' energies. And the point to be emphasized is the fact that these activities, together with the habit training, are such as to bring the patient again into contact with reality and to lead him out of his self-absorption back into a measure of normal life. Even though this may remain a more or less restricted life, to a great extent routine in character, much has been accomplished in that the patient has been rescued from the profound delapidation that is almost inevitable in a large percentage of this class of cases."

CONTROL OF VENEREALLY DISEASED PERSONS IN INTERSTATE COMMERCE. By David Robinson. *Public Health Reports,* 36:2210-15, September 9, 1921.

The federal government has but little power to control the spread of diseases in the states. It has, however, passed laws that aim to prevent the spread of contagious diseases in interstate commerce. In addition, Congress has authorized the Secretary of the Treasury to promulgate regulations in regard to it. Under this authority, Amendment No. 7 was added to the Interstate Quarantine Regulations, which amendment regulates the interstate travel of venereally infected persons. It is not the object of the federal or state health officers to prevent venereally diseased persons who go to another state in search of medical treatment; but the amendment is aimed at diseased prostitutes, procurers, and vagrants, who not only neglect treatment, but deliberately expose others. Some states have adequate follow-up systems and notify other states directly or through the Public Health Service when an infected person ceases treatment without permission and goes to another state. No difficulty has been experienced in inducing such persons to resume treatment. Any persons convicted of violating the Interstate Quarantine Regulations who come from communities in which there is no provision for treat-

ment will be detained and treated at the expense of the United States Government. Much can be accomplished in controlling venereal diseases if a strong coöperation exists between the health officers of the various states. Another strong legal measure is the provision of state laws requiring that physicians report names and addresses and other facts relating to venereally infected patients who refuse to continue treatment or who are likely to spread the disease. Many physicians have been able to induce patients to continue treatment simply by calling attention to the existence of these laws.

BOOK REVIEWS

THE WORLD IN REVOLT: A PSYCHOLOGICAL STUDY OF OUR TIMES. By Gustave Le Bon. Translated by Bernard Miall. New York: The Macmillan Company, 1921. 256 p.

The author of this book is already well known for his many previous works, all of which approach important sociological issues from the psychological point of view. His thesis is an important one for the mental hygienist, and as he carries his argument along, he makes it very convincing that the future direction of important social, economic, and political movements can be wisely guided only as a result of psychological insight.

Le Bon traces the psychological factors that entered into the cause of the war and discusses the question of morale, the way in which morale was supported by the belligerent nations, and how its destruction resulted in the collapse of Russia and of Germany. He traces further the psychological factors that have operated since the war and are at the basis of existing economic disturbances and social and industrial unrest. And, finally, he takes up an examination of Bolshevism.

In his discussion of Bolshevism and other regressive movements, he calls attention to the principles that he has previously enunciated relating to the psychology of the crowd, and shows how the efficiency of society is dependent upon its *élite* and that it is impossible to substitute for them groups of untrained and uneducated individuals. Quantity in such cases is never able to take the place of quality. Society needs leaders, and when an effort is made at self-government through assemblages of large numbers of individuals of mediocre ability, the results can never be upon a sufficiently high level to insure progress and efficiency. An assemblage is a crowd and can meet in agreement only at a level that the constituent elements possess in common, which means practically the wiping out of all the superior traits and the dropping to a lower level of reaction.

The author also emphasizes, what should be well known facts, that beliefs are affective in origin, that they spread by contagion, and that they are not controllable by logic and reason—the same sort of conclusions that we are familiar with in the field of the psychoses. He argues, therefore, that the origin and the growth and the understanding of beliefs should be adequately investigated, so that effective ways of dealing with false beliefs and of propagating potentially valuable ones could be discovered.

While the reader may or may not agree with certain of the specific conclusions of the author, he cannot but agree that the method of approach to these problems as outlined is one of sanity and judiciousness and is the method of science rather than of political opportunism.

William A. White.

St. Elizabeths Hospital.

The Analysis of Mind. By Bertrand Russell, F.R.S. New York: The Macmillan Company, 1921. 310 p.

It satisfies the indolent side of being to dream of resolving the pluralities of life into a future oneness. Creative science is animated by a different spirit. It represents the phase of being that is stimulated by the multiformities of reality. It delights in the many manifestations of the functional activity of reality as it is roused to their investigation. Continued investigation also leads away from fixed conceptions which hamper thought by insoluble perplexities. Thought is invited always to seek something behind the more manifest phenomena. This is not to find an ultimate unity of origin where at this end one can rest from change. It is rather to discover a unity out of which all the inspiring varieties of manifestation arise to reveal the dynamic versatility of reality. Therefore, if science leads thought thus, it stimulates it to share in the activity of reality, not to seek release from it.

Such is the healthy tendency of Bertrand Russell's investigation of mind. He expresses the spirit of much of the philosophy of today and of the psychological investigation that supports it. He introduces us not to facts which in their final convincing power satisfy thought once and for all. On the contrary, there is a stimulating uncertainty in his own mind as to the statements that he puts forward. He uses them merely as tools for the opening of paths of investigation that lie in the future of thought. He aims chiefly to convince himself and his readers that behind the apparently insoluble difference between mind and matter there is a common background of more primitive stuff. Mind and matter are then only different constructions of this original material. Physics groups the particulars of any portion of this reality "by their active places"—that is, as these particulars proceed from such object as its effects or appearances in different places. Psychology, on the other hand, groups particulars "by their passive places"—that is, by the appearances or happenings as viewed from a given spot. Psychology is distinguished by its own causal laws which might be named subjectivity and mnemic causations.

It is not necessary, under such a view of only a causal difference

between physics and psychology, to call oneself an idealist or a realist. A realist Russell asserts himself to be only as regards sensation, which represents the intersection of the physical and the mental. Beyond sensation mental phenomena obey certain other causal laws than those operative in physics. The duality of the two systems lies, therefore, not in their material, but in their causal relations to reality.

Russell occupies himself with an investigation of mental phenomena for the proof of this view, in order that thought may be led further into such a greater freedom with its material. He inquires into some of the possible fallacies of older conceptions which have prevented such elasticity of attitude. He examines consciousness in doubt of the correctness or the scientific usefulness of its assumed position as the essence that constitutes the uniqueness of mind. It is not a universal characteristic of mind nor is it so simple a thing as has been assumed. It is not, therefore, a primary distinguishing characteristic of mental life. Russell cannot reduce his thought to the mere materialism of the behaviorist. He acknowledges the debt that advance in psychology owes to the behaviorist's point of view in sharpening thought to the observance of response to stimuli and the importance of the latter as at least a practical phase of knowledge. In his view there is, however, something more to be taken into account. He considers that there are not only grounds for relying upon introspection to a modified extent, but a necessity for it in order to reach certain mental functions that elude merely external observation.

Perception, memory, and belief, he goes on to show, are factors that have their part in mental life. Desire with pleasure and pain—or discomfort, as he believes the latter idea is to be more accurately expressed—are also not to be left out of account in the attaining of cognition. He proceeds to investigate these elements separately to show them as not only existent, but trustworthy for psychology if they are considered as part of the causal system which distinguishes the psychic life.

His discussion of instinct and of desire brings us to the more fundamental nature of these, a recognition of which delivers them from the fallacious confusion with which they are commonly obscured. He leaves out the static cataloguing of "instincts" with which psychologies are too often cluttered. Yet one could desire greater clearness between various "instincts" and the pure conception of instinctive manifestation that serves vital needs. He might have kept himself more distinct in regard to reflexes and habits, both of which are means acquired for serving instinct and therefore rather more sharply to be distinguished from instinct itself. He admits the "complications which blur the sharpness of distinction" here. It is

a blurring that somewhat pervades his later discussion. He does well, however, in releasing the conception of instinct from an idea of prevision. Only its service in bringing to pass, directly or through whatever complicated acquired processes, the satisfaction of needs might have been brought to clearer statement. He has pointed in this direction, however, thus turning the reader toward that greater simplicity.

This conception is clearer as he carries it into the discussion of desire. He has allowed himself to be confused as to the position of psychoanalysis, even while he acknowledges the aid of the latter in certain directions. He himself distinguishes in an exceedingly useful way between the desires one thinks one has and those that are deeper, perhaps inherent, and usually concealed. He complains about the air of mystery that psychoanalysis seems to have thrown about the subject of desires. Did he know psychoanalysis more practically, he would realize that it is engaged in the very work he advocates—the separation, through clearer knowledge of the deception, of our consciously defined desires from our actual instinctive ones and the solving of the conflicts that such self-deception produces in the mental life.

The book is one of advance in the direction of a plastic attitude of thought and investigation. It presses not only into the deeper background for a psychological science, but a simpler statement and therefore a clearer understanding of the nature of the mental life. Thus does psychology come more definitely into its place as a cognitive science.

Smith Ely Jelliffe.

New York City.

The Management of Men. By Edward L. Munson, M.D. New York: Henry Holt and Company, 1921. 801 p.

Colonel Munson is an officer widely known as the designer of the Munson last of the army shoe. This volume thus represents a further sublimation and *Verlegung von unten nach oben,* in that, having previously aided us to walk comfortably as well as uprightly on the pedal level, he now offers us a guide to all our wills and ways. The book is a synthesis of military administration and psychological science. From the standpoint from which the psychologist can criticize, the result is successful. Our formulations are still in a very provisional stage, and in this as in any psychological work ideas must be voiced in regard to which common ground has not yet been reached. The sources of current psychological conceptions have been examined with understanding care. Authorities are not named, but the guess

is hazarded that McDougall has influenced the author more than has any other psychologist, to the good fortune of both.

Of comprehensive proportions, and of style clear and dry, the book lends itself to reference rather than to reading. The psychologist's impression is that the first part is too detailed, the second part not enough so; but the military reader might well take an opposite view. The earlier portion develops the system of psychology which the author applies to the problem of military morale. It is pointed out that the aims of modern war are essentially psychological, the creation of desired mental states in the enemy. German morale was built upon belief in superiority, and secondarily, if at all, upon faith in the abstract justice of the cause. Thus they did not stand up under reverses as well as did the Allies. Their morale system gave more attention to undermining that of the enemy than to upholding that of their own troops (Russia, Caporetto). Sometimes measures well enough calculated for their own racial psychology—such as the suppression of adverse news—were misapplied with enemy peoples ("frightfulness" in Belgium). The American soldier responds less well to direct commands and better to rationalization, or appeals to the group spirit. Stress is laid on the opportunities of turning perverted leadership to good account. (In Monckton, *Taming New Guinea*, it appears almost as a routine practice to sublimate the community bad man into a village constable.) An essential factor in mass appeals is simplicity, and especially something of the imaginal type; in which connection are discussed the flag, insignia, the slogan, the poster. A cause of fear is found in "blocking the instinct of self-expression", as seen in the shaken morale of reserve troops held under fire to which they cannot reply. This is a formulation interesting to compare with the Freudian conception of the fear neurosis. The relation between war and the "instinct of pugnacity" is perhaps more complicated than is made to appear. Certain objections might be raised against regarding such an instinct as the chief, or as other than a minor, factor outside the actual combat. But in general this discussion of the interplay of instinctive and affective processes is a portion of the book very commendable for collateral study by the psychologist. The remarks on hatred and shame are particularly well found.

The enumeration of the special points above is in no way to be taken as an outline or indication of the book's contents, which cannot be attempted in this note. Each chapter is headed by a summary of its contents. Particular mention might be added of the classification of the "mental and physical morale agencies" (page 54); the listing of the functions of the morale officer (page 320); the

text of the War Department circular on the duties of the morale officer (page 386); and the charting of the morale organization (page 390).

Further details of the morale system as conceived by the author are left to the student of his work, except that allusion may be made to the keystone of the system, the "morale operative". This vital functionary seems all too briefly dealt with. In the average military organization, members who have the special privilege and duty of reporting any feature of their comrades' conduct that may fit their subjective judgment of "morale" operation should occupy positions of unusual delicacy, to say the least. "An', Tommy, 'ow's yer soul?"

The reviewer is not able to name a more thorough assimilation of well tested psychological principles, or an application more consistent over a wider range of human behavior. It is gratifying when psychology of this kind is written by a psychologist; it is magnificent when it is written by one who is not.

F. L. Wells.

Boston Psychopathic Hospital.

The Eugenic Prospect: National and Racial. By C. W. Saleeby. New York: Dodd, Mead, and Company, 1921. 238 p.

This is a book on eugenics which recognizes that race deterioration may follow from environmental conditions. This in itself puts it in refreshing contrast to those contributions which are based on the belief that the germ plasm is somehow operating without any contact or influence from the outside world. In fact, it has become a sort of biological heresy to intimate that there are conditions that may change the germ plasm, and it has become a biological fetish that there is only one factor worth talking about and that is heredity.

Dr. Saleeby takes notice of the fact that valid experiments have been performed which prove that there are race poisons and that these race poisons may operate to produce defective individuals, and further, that this defect may continue from generation to generation. Medical men should not have needed these experiments to substantiate this belief, cognizant as they are of the fact that the same blood stream which nourishes and energizes the rest of the body nourishes and energizes the germ plasm. Those of us who live in a world of clinical realities will not be at all surprised to learn some day that a passing infection may injure the germ plasm and account for defective individuals for several generations, and that malnutrition may do the same.

Dr. Saleeby is a wee bit too enthusiastic about the eugenic measures of America. It is likely that the backward attitude of England

prejudices him in favor of our country, but no American need share his enthusiasm, though we may congratulate ourselves that we are a little better than our neighbors. Dr. Saleeby takes up the environmental poisons that in his opinion may injure the race. He thus speaks of alcohol, of diet, of the disgenic effect of war, and the revelations that the war has brought.

He finds it worth while for the eugenists to consider population pressure, and believes that in order to prevent future wars, which are horrible disgenic factors, "any society of nations must either provide for future modifications of frontiers in order to obviate the dangers of juxtaposition of one hungry, tightly aggregated population with another sparse and abounding in food, or provide for immigration and emigration so that these dangerous inequalities of population pressure with their explosive risks called wars may be averted". The orthodox eugenists seem on the whole to regard war as a good thing, and to believe that, like disease and such factors, it removes the unfit. That all the experience of mankind is against this view does not influence these doctrinaires. Though not original, Dr. Saleeby's chapters on this matter are worth the attention of every one who values the future of the human race.

The author points out the deterioration of the physical qualities of the inhabitants of the British Isles in trenchant fashion. He says, and quite truly, that youth has been neglected, and that owing to this neglect England is paying the penalty with a population of which three out of every four were found unfit for service. It may be objected that the mere fact that young people do not have sufficient food, live in dark quarters, do not play enough or properly, and start to drink and smoke too early, is of no importance to eugenics. The reviewer is very glad to second Dr. Saleeby in the belief that these things injure the germ plasm residing within these young men and women, and that a true eugenics must be a social hygiene as well. This, of course, is in direct opposition to a certain class of the eugenists who believe that all our measures of hygiene are merely keeping alive the unfit, and that as a result of medicine we have a process of disgenics at work.

One becomes lost in admiration of a eugenist who can pay attention to such a fact as the relative values of the kitchen range and the gas range. The kitchen range, according to Dr. Saleeby, produces the abomination of soft-coal smoke, and this poisons the urban communities and the urban inhabitants and thus is a disgenic factor. He goes into some length on the heating of homes and the doing away with smoke and dirt, not merely because these are good for the individual, but for the deeper and more important reason that they are good for the race.

Enough has been stated to show that Dr. Saleeby is dealing with the laws of hygiene and eugenics. He does not believe that nature and nurture are opposed to one another, but that bad nurture in its widest sense may produce what may become hereditarily bad nature. On this point, of course, he would be opposed by most biologists and by most of the eugenists of America, but if there is one thing that the 1918 epidemic of influenza showed, it is this—that epidemics do not necessarily select the weak and the unfit, but may select by preference the strong, the robust, the well-nurtured, and the well-natured. In the army camps of America and the world over, the husky young fellow of good family and fine physique was carried off by germs that hardly affected his runty, slope-shouldered comrade. In other words, if hygiene could have prevented the influenza epidemic, it would have prevented a factor tending to deprive the race of its best, not its worst. The diseases of childhood are not especially more frequent and more disastrous in those of poor stock than in those of good stock *except where the conditions of nurture protect the child.* On the whole there is no evidence to show that the best mental and moral types or the best physical types resist disease any better than do individuals inferior in these respects. Consequently hygiene is not opposed to eugenics. In pointing this out in a charming manner, Dr. Saleeby has done a real service, and his book should be read by all who have felt disheartened at times by a cynical attitude of eugenists towards humanitarian efforts.

A. Myerson.

Tufts Medical College, Boston.

The Glands Regulating Personality; a Study of the Glands of Internal Secretion in Relation to the Types of Human Nature. By Louis Berman, M.D. New York: The Macmillan Company, 1921. 300 p.

After having read this volume of two hundred and ninety pages, we are racked by thoughts that crowd one another in their attempt to compel us to utter them. First of all, for whom was the volume written? Certainly not for the physician, for no medical work since the Middle Ages has made use of the flowery figures of speech that our young friend has in this work to drive home scientific facts. It makes one wonder whether the style is not, perhaps, incense to overcome our critical natures and disarm our reason. And then, having been thus overcome, we are treated to an exposition of what heretofore has puzzled our little minds and caused us to wrinkle our brows in perplexed thought for ages gone. Here are solved for us: the nature of memory, the reason for fear, the difference between terror and fury, psychoanalysis, why was Napoleon, and it even seems to the semi-

narcotized reader that somewhere in the volume there is given an adequate reason for the boiling heat of the sea and the sprouting of wings on pigs. While the subtitle states that the volume is a "study of the glands of internal secretion", it seems to the reviewer that the book gives a series of statements about them which have all at some time or another been made by many and various investigators—and most of them not sound at that—but as for a *study,* that would be far to seek.

Take the statement on page 88 relating to the pineal gland: *"Imagine it! somewhere, stuck away in a cranny of the floor of your head and mine, is this descendant of an organ that once sparkled and shone, wept and glared, took in the stars and hawks and eagles, and now is condemned to eternal darkness and an ineffectual sandiness. To-day we have not discarded that view of history", etc.*

Here you have, *in parvo,* the entire book! The anatomy is wrong, the comparative morphology is wrong, the interpretation is wrong, and modern medicine has for some time recognized that the above historical view is also wrong. First, to be more explicit, the pineal gland is not in a cranny of the floor of the skull. Secondly, the pineal is probably not a vestigial structure related to the third eye of the lower vertebrates, but is glandiferous. It grieves us to have to bother Frederick Tilney to support this view of the pineal structure. His exhaustive work on this particular matter stands unchallenged to-day. And finally, as for the tears that in the bygone ages this darkly placed vestige must have shed—they were probably crocodile tears anyway and so ought not to count.

And so we have decided that the book could not possibly have been meant for physicians.

Perhaps the psychologists were the envied class addressed. On page 176 we read: "Some people are not easily frightened, others are more readily frightened, and still others are of an extremely fearful nature." Why, we pause to ask, should this class inequality exist? Millions of words have been wasted on this problem. Berman states the fact to be that *"it depends upon the proportion of adrenal cortex to medulla secretion in them, and their reaction to fear stimuli is a pretty good measure of the ratio".* Nothing simpler! We have a deep-seated feeling that the rôles of Mephisto and Faust are being reënacted and that the secrets of our existence have been peddled. And intellectuality? *"By intellectuality we mean the capacity of the mind to control its environment by concepts and abstract ideas. The ante-pituitary has been depicted as the gland of intellectuality."* Verily, no doubt remains. *"Character is a matter of standards in the vegetative system, and is the grand intravisceral barometer of a personality."*

The speed and energy and sureness with which the author delivers himself of dicta settling questions that have bothered this little old world for centuries make us gasp. The use that he makes of theories that we recognize as belonging to friends of ours—who are not so sure of them themselves—by building superstructures of character traits, personality reactions, historical interpretations, is nothing short of marvellous. But are they true? Nowhere in the volume does he give us an inkling of his own experiences or experiments with humankind. His material is drawn from newspaper reporters, moving pictures, and historical sketches. Truly a vast fund from which almost any kind of material suitable to one's theories may be found. Anything can be proven about everything. But psychology! Heaven save the mark!

It must, therefore, be to the lay reading public that Berman addresses himself. His title, as with all titles, need have no bearing on the subject matter whatever. The subject need but be interesting, mystic, couched in highly figurative speech, without any serious consequences even if occasionally self-contradictory, and ought to touch upon all the newest themes in vogue in the "Village". This makes interesting reading, creates subjects for dinner discussions among the *male-female* and *female-male* habitués of the place, and so keeps them happy and busy. And so the book has its place.

To catalogue the errors, the unproven statements, the many self-contradictory deductions, would be to catalogue the two hundred and ninety pages individually with a special glossary. It would be wrong, however, to say that there is nothing worth while in the book. For every theory, from Crile's "kinetic drive", through Rogers' "check and drive" and Timme's "compensatory syndrome", is cited, though not always with authorship credit, and the use made of these bases for the author's purposes is, to say the least, interesting. That the glands of internal secretion do have a bearing upon personality reaction is almost certainly true; that the relationship is one of control is just as certainly overstating the matter; but, in any case, simplicity in the mechanism is unthinkable. Some of the cruder interrelations that Berman describes have also been tentatively advanced by others and may be said at this date to be borne out by our experiences with many of our cases. Fascinating as speculation may be, it is much wiser to analyze the conduct of our patients with coördinated laboratory, clinical, and psychological methods than to hope to predicate conduct and behavior from the grossly physical exterior alone. We should like to have Berman give us a really scientific exposition of one or two of his adreno-centric individuals—or adreno-tropes, as Joseph Fraenkel called them—with the laboratory findings, the psy-

chological reactions, the physical determinants, and his reasons for basing their personality reactions upon the comparative size of adrenal cortex and medulla. The book will undoubtedly find many interested readers—but, let us hope, discriminating ones.

THE NEW PSYCHOLOGY AND THE TEACHER. By H. Crichton Miller, M.A., M.D. London: Jarrolds, Ltd., 1921. 231 p.

That education is to be profoundly affected by the new data psychologists and psychiatrists are collecting in regard to the intellectual and emotional life of individuals, one feels quite sure. The influence of these data can already be observed, but scarcely more than a beginning has been made. A number of books dealing with the subject have been issued during the last two years, but on the whole they have been disappointing. Some have been almost fantastic in the size of the air castles their authors have had the courage to build on very slight foundations—like much that is now being put out for popular consumption on the important subject of glandular therapy. Others have been of very considerable value to the professional student of psychology or psychiatry, but quite too technical and involved for the teacher or parent. One welcomes, therefore, Dr. Miller's book. One may not agree with all that he has to say, but everything that he says is worthy of thoughtful consideration by all who have to do with children. He does not build fantastic air castles, and he has written simply and clearly. It would not seem that any intelligent person should have difficulty with the book.

Dr. Miller's point of view can probably best be given by quoting him. "There are roughly two aspects to education", he says, "the one the transmission of racial experience; the other, the development of the individual psyche. Each makes a different demand upon the child; and, if the teacher is to get below the surface in his educational methods, it is essential that he should set himself to realize the meaning of these demands that are made by himself or others, and also to understand the nature of the child's reaction to them." As to the development of the individual psyche, we may speak of it broadly "as self-realization, using the term to include the complete adjustment of the individual to life in all its aspects. Towards this goal the child is impelled by an energy which is not derived from the influence of parents or teachers or from any external force. The impulse towards growth is simply the biological urge to completeness which is found in every living thing. We come into the world with it, and it remains as the constant impulse towards a goal which is only attained when we reach maturity, and either express or sublimate

all our instinctive ambitions and potentialities. It is not primarily spiritual, but biological, and it is largely unconscious. It follows that a great deal of a child's growth, a great many of his ambitions and aspirations, are directed towards the primary, central, and perfectly unconscious motive of ultimate parenthood, because this is the essential biological expression of maturity. The human herd has become so complex and bewildering a thing that this great fact of parenthood being the token and visible symbol of maturity is largely obscured. Moreover, the human ideal of development is not purely biological, but has become enriched by ethical, social, and religious conceptions. In spite of this, the original biological nature of the impulse to growth and to completeness is not to be ignored.

"It is evident that, though this principle of growth is universal, it is not irresistible. It is infinitely liable to hindrance and deviation and delay at all points. The child's development toward completeness is very easily thwarted. If the urge to maturity is primarily biological, the barriers in its way seem to be almost invariably psychological; and for these barriers parents and teachers are commonly responsible. We put up a barrier when we restrain children unnecessarily; when we put difficulties in the way of their self-expression; when without reason we demand that they should inhibit interest and activity which seem to them to be perfectly harmless. This is the barrier of authority. The second barrier is raised when we offer to the child a world that is too harsh, too puzzling, and too difficult for its powers of adjustment. This is the barrier of reality. These are the two great problems of the child; and the test of his achievement is whether, when he reaches maturity, he has made the three great practical adjustments that life demands: the adjustment to society; the adjustment to the mate (actual or potential); and the adjustment to the Infinite."

Dr. Miller than proceeds to discuss the part that suggestibility plays in the adaptation of the child to authority and of phantasy to reality. These two chapters, it seems to me, are exceedingly suggestive. One would like to quote largely from both if space permitted. Of particular interest is his discussion of the rôle of fairy tales in the life of the child. A chapter on the emotional development of the boy and one on the emotional development of the girl present a point of view that is familiar to students of analytical psychology, but that is likely to be new to many teachers and parents. There follow chapters on unconscious motives, mental mechanisms, dream symbolism, the herd instinct and the herd ideal, and a final chapter on educational methods.

In his introduction, Dr. Miller points out a defect in his book:

"The limits of the book have made it unavoidable that some subjects should be touched upon with a misleading degree of simplicity." A reviewer feels this defect, particularly with such a chapter as that on dream symbolism. To discuss dream symbolism clearly in twenty-three small pages is practically impossible, and not to discuss it clearly in such a book is likely to cause confusion and misunderstanding. But in a book so excellent this is a minor point, even if one to be regretted. Dr. Miller has done parents, teachers, and mental hygiene in general a service in making available in this book a series of lectures that must have caused those educationalists who first heard them to become very thoughtful.

FRANKWOOD E. WILLIAMS.
The National Committee for Mental Hygiene.

SEVEN AGES OF CHILDHOOD. By Ella Lyman Cabot. Boston: Houghton Mifflin Company, 1921. 321 p.

At this epoch of social development, during which period the child-welfare problem has become firmly fixed as a part of a great public-health movement, Mrs. Cabot presents this timely volume upon the seven ages of childhood. The book, as the author states in the introduction, is a sketch of childhood, divided into seven overlapping periods, from the time of birth up to and including the "coming of age", the period in which serious problems of various types present themselves both consciously and unconsciously.

The development of the first three years of life is covered by the first book, *Babyhood—The Dependent Age*. The author refers briefly to many of the developmental reactions to which the average child readily adjusts himself and hints at the early appearance of responsibility. Book two is *The Dramatic Age*. This is the age of real childhood. The child's creative fancies, as brought forth by the imagination, are of immense value in opening up the secrets of this mysterious world, when properly guided and directed. Book Three, *The Angular Age*, treats of that period of latency during which many so-called "faults" develop and from which the child is attempting to free himself. *The Paradoxical Age* and the *Age of the Gang* (Book Four and Book Five) deal with the pre-adolescent and adolescent periods. The author describes the disharmonies existing between the brain (mind) and the body; she notes the frequent occurrence of opposite traits in conduct and behavior; and she observes the lack of sincere understanding as a factor in producing these disorders. The Sixth Book, or *The Age of Romance*, discusses the unfolding of the emotions. During this period the individual is concentrating all his efforts upon the adjustment of himself to himself and to society.

A proper adaptation throughout this age brings him to the development of his ambition, the choice of a vocation, and the reaction to marriage, as is discussed in Book Seven, *The Age of Problem.*

The traits manifested in these various stages will serve as indicators, not only in the normal development of the individual, but also in the abnormal. A keen observer may utilize such factors to open the pathway for a deeper study into the personality and the harmonizing of that personality in the family circle, in the choice of friends, or in society.

In conclusion, it might be said that the author has presented the story of child development to the layman in a very readable form; the book will be most useful to all workers in the field of child welfare.

FREDERIC J. FARNELL.

Rhode Island Society for Mental Hygiene.

TRADE TESTS: THE SCIENTIFIC MEASUREMENT OF TRADE PROFICIENCY. By J. Crosby Chapman, D.Sc., Ph.D., with the assistance of Daisy Rogers Chapman, M.A. New York: Henry Holt and Company, 1921. 435 p.

When Dr. Goddard, in his Vanuxem lectures at Princeton (later gathered together under the title *Human Efficiency and Levels of Intelligence*), proclaimed the logical necessity for social control of the 96 per cent of infra-superior minds by that 4 per cent that Giddings calls the "protocracy", he reached the crux of his argument in the question of confidence. That it would be desirable if the "best" minds could govern has been a commonplace, in the world of ideas at least, since Plato. That mankind would be happiest and most efficient if every human being were doing the work to which he is best adapted by nature is a thesis almost equally old. The only new and shocking notion was the finding of contemporary, and especially military, psychology that the actual distribution of individual mental differences in a representative cross section of humanity is so different from our preconceived equalitarian beliefs. Dr. Goddard said:

"Whenever the four million choose to devote their superior intelligence to understanding the lower mental levels and to the problem of the comfort and happiness of the other ninety-six million, they will be elected rulers of the realm, and then will come perfect government—aristocracy in democracy."

They might—given those ideal conditions. But that is just the rub. The establishment of the "aristo-democracy" awaits the perfecting of a technique of confidence. Such revelations as these have always aroused—and there is no indication that they will not continue to arouse—in the breasts of the great average only resentment,

incredulity, and opposition. A failure to recognize this fact has been the most conspicuous deficiency hitherto of the eugenists, the clinical psychologists, the line-and-staff officers, the efficiency experts, the personnel managers, and other groups in positions of power and influence, when called upon to deal with these problems of intelligence levels. Their social psychology is marred by a blind spot that will not permit them to earn that essential confidence. They have not devised a methodology of adaptation that appeals to the sense of justice and satisfies the affective demands of the rank and file of industrial workers. Here and there, emerging from the conventional disciplines of varied sciences, certain minds have glimpsed light on this problem and have begun to grope toward a psychology to meet it—Parker, Southard, Marot, Veblen, Link, Tead, and others. The economists and the psychiatrists are meeting each other with open minds now.

A prime factor in the creation of confidence, and one so far largely lacking, is the objectifying of methods in such form that the worker cannot question their impartiality as well as their efficacy. A new current, arising in "applied psychology" and bearing fruit in the work of the Army's Committee on Classification of Personnel, has now turned its attention to civilian industry. Dr. Chapman's valuable book is the record of that growth by one who has been through the thick of it and who, with the possible exceptions of Drs. Scott, Thorndike, and Bingham, had more to do with it than any one else.

Trade Tests is not intended as a contribution to the psychiatry of industry, and such principles as it utilizes of this nature are incidental, but they are symptomatic. Speaking of the kind of employment interviewing in which "the whole object of the procedure seemed to be to prevent the 'interviewer' from appearing to lack thorough trade knowledge", the author says (p. 365):

"When the examiner is out of his depth, the skilled workman is the first to detect the fact. Under these conditions, he feels that he is either passing through a purely formal examination or else that he is being made a fool of. Both of these situations are unfortunate for the reputation and effectiveness of the employment office. All who have worked in industry know how important it is that a good understanding exist between the various shops and the office, an understanding that should not be confined merely to the foreman, but should extend to each man in the plant."

Varying types of trade examination have varying values here in respect to the morale of the men. But Chapman believes that the importance of this point can be overestimated. In examining several hundred men each day for several weeks, in eighty trades, in a large

employment office, he found only four cases in which the applicant openly expressed his skepticism and disapproval of the oral examination (p. 384).

The book is mainly a straightforward account, with copious examples, of the nature, construction, and administration of the army trade tests, together with some more speculative chapters on the analogies of the military to the industrial problem and the application of trade testing to the latter. The trade tests grew out of a series of arbitrary questions called "aids to interviewers", designed to meet the emergency during the early days of the war. Analysis showed that the army utilized somewhere or in some part of its organization the astonishing number of 714 distinct civilian trades and occupations. The waste involved in fitting millions of recruits to these niches by the haphazard trial-and-error methods that first obtained—and that still largely prevail in peace-time industry—cannot begin to be estimated.

Some means had to be devised to differentiate between various degrees of trade ability, on the assumption—which later became almost a fixed law—that there is so high a correlation between the elements of information and skill in a given trade ability as to make the possession of the former a reliable credential of the presence of the latter. Individual interviewers could ask arbitrary questions covering an entire process, the answers to which might vary widely in scope and acceptability. On the strength of such answers, they could give only subjective judgments of a tradesman's skill, with a large margin of personal equation. But eventually the substitute method was evolved of the objective "single-answer" question, necessitating no special trade knowledge on the part of the examiner, limited to a specific detail of the process, but one that is strategically essential to wider knowledge, and answerable, with but slight variations, in only one way for which credit can be allowed.

The story of how the completed and standardized trade test is built up is fascinatingly told by Chapman, but must be passed over here. Each test consists of twenty questions which, in sum, yield quantitative scores, "calibrated" to differentiate four grades of trade ability—the novice, the apprentice, the journeyman, and the expert. But the book is really a manual that would enable any intelligent personnel manager to build his own trade tests for specific trades.

Two alternative forms of tests were also devised for army use—the picture method and the performance test, both aiming to realize more fully than the oral test the actual conditions under which the trade is performed. Each has its advantages and is obviously adapted to certain types of trades.

The trade-testing movement is as yet but in its infancy. It has a distinct field of its own, not to be confused with that of intelligence tests, skill-prediction tests, or the ingenious techniques that are now being devised for measuring emotional and volitional elements of personality. It is a highly practical attack upon a crying socio-economic problem, based upon rigidly objective and statistical methods that are ultimately the genius of all science. It is a long step forward in the direction of a better adjustment between human capacities and material needs. That it will contribute illuminating insights to many psychological and psychiatric tangles is all but a certainty, and Dr. Chapman is to be thanked for providing the first authoritative discussion of the field.

Kenneth M. Gould.

American Public Health Association.

Studies in Dreams. By Mary Arnold-Foster. New York: The Macmillan Company, 1921. 178 p.

This volume is an excellent lay example of the type of discussion that was common a few years ago in polemical medical literature in opposition to the so-called Freudian psychology; that is, the argument was that one believed in Freud's theories, but not to the extent to which Freud expounded them. The present book is a complete exposition of this view. It is unnecessary to say that the author's courage in giving an account of her own dreams is equaled only by the obvious incompleteness of their interpretation, however fair and open-minded she seems in her approach to this task. No violence is done to the general Freudian doctrine of dreams except, perhaps, in a few instances. The manner in which the author believes that the so-called power of conscious will can direct the unconscious dream thought, and thus alter the character of the dream, is an instance in point. If the author means that she consciously desired to dream flying dreams in their general trend, well and good; this may be possible. Again, referring to her chapter on dream control, that the conscious will may be able to strengthen the censor or semiconscious resistance to that point where the conflict becomes too great for the nightmare to proceed, and thus awakens the individual—this, too, may be possible. However, the general proposition that the conscious may be taught actual will control over unconscious activity in dream content seems quite contrary to our clinical experience. It is interesting to note that in all her flying dreams the author's behavior is as if she were moving in a fluid rather than through air, thus tending to prove that these dreams of omniscience are really regressive in type, analogous to instances of metro-erotism cited *in extenso* by many of us in neuroses and psychoses.

A clever and adroit foreword of eighteen pages by Morton Prince commends the volume, especially those parts that lend support to his well-known interpretations of dreams and his antagonism to many Freudian concepts. The important chapter headings are: *Dream Control; Flying Dreams; Dream Recording; Dream Memory, Dream Imagination, and Dream Reason; Symbolism in Dreams, and the Significance of Dreams in Tradition; Dream Places; Dream Construction; Sense Impressions in Dreams; The Actors in Dreams; Moral Sense in Dreams.*

The author's literary style is simple and thoroughly enjoyable reading, though seemingly too naïve for one so skilled in writing.

New York City. L. PIERCE CLARK.

THE CONTROL OF SEX INFECTIONS. By J. Bayard Clark, M.D. New York: The Macmillan Company, 1921. 132 p.

This is a very readable little book. The author served in the Medical Corps during the recent war with great credit to himself and, if one may judge by this publication, his experience was extremely profitable.

The first six chapters outline in a very general way the whole situation as regards the venereal-disease problem. These chapters are excellent reading, though there is very little in them that is new. No one could possibly contest a single point. In fact, the whole field has been covered so many times before that one begins to wonder what excuse there is for writing it all again. Here is the excuse—the author's solution of the problem, which is as original as it is ingenious. This is it—universal military service for youths and compulsory summer camps for girls, physical upbuilding, sex instruction, and vocational training, the last for the purpose of making possible early marriage, well recognized as one of the best means of preventing venereal infection. And all of this for all the boys and girls of the nation at the age of greatest receptivity. This is not all of it, but it is really the high point—the excuse, and a sufficient one, for the publication. In addition to being a new argument for universal service, it is a genuine constructive program in the campaign against sex infections.

It would not be fair to conclude without mentioning two more points—namely, the style, which is delightful, and the description of the author's tactful and efficient administration of his war hospital.

Dr. Clark concludes his preface as follows: "Though I remain acutely conscious of the many shortcomings of this small volume, I still trust that it may prove to be in some degree suggestive." The contribution is more than suggestive; it is material for serious thought. HARRY N. KERNS.

Medical Department, U. S. Military Academy, West Point.

MANPOWER. By Lincoln C. Andrews. New York: E. P. Dutton and Company, 1920. 150 p.

This book is said by the author in his foreword to be an adaptation of a previous volume called *Military Manpower*, his purpose being to apply the principles of army leadership to the social and industrial problems of civil life. No doubt an acquaintance with the preliminary work would be desirable as a basis for a fair criticism of the present one. Such a knowledge the reviewer lacks and acknowledges that in so far his opinion should be discounted.

The impression is gained, in the first place, that the author is a good officer and an upright, kindly gentleman, with a deep interest and respect for those of his fellow-creatures who happen to be under his command in any capacity. At the same time there is much of benevolent paternalism in his attitude in spite of his emphasis on real democracy.

He has made the attempt to draw from his broad army experience in handling men general principles that may be of use to others in any capacity of leadership, whether it be as foreman of a construction gang or governor of a state. In doing this, he appears to have gone considerably beyond his depth and to have floundered for a hundred and fifty pages in a sea of generalities without special course or direction.

Some sermons leave the hearers with a comfortable feeling of having had the trite and the obvious well presented in a manner not to cause a ripple on the smooth surface of their complacency. Thus one may read this book, agree heartily with its doctrine, and yet feel that neither in knowledge nor power has one added one whit to one's previous capacity.

The author's attempt to divorce his teaching from the special viewpoint of military relationships has not been altogether successful. The whole discussion seems to hover around the company or regimental organization, and to be held away from it for general application only by forced manipulation.

To the unformed mind of boy or man, there will be points of value in this book. Its usefulness to those with any degree whatever of executive experience will be doubtful.

MARTIN W. PECK.

Boston Psychopathic Hospital.

JUVENILE DELINQUENCY. By Henry H. Goddard. New York: Dodd, Mead and Company, 1921. 120 p.

This is a readable, well-written little book. It discusses the causes of delinquency and crime, the organization of the Ohio Bureau of Juvenile Research, the results of physical and mental studies of juve-

nile delinquents by this bureau, and recommendations as to further studies and methods of controlling delinquency.

Attention is called to the fact that we are beginning to inquire why a child is delinquent and to learn "that disease and defect, mental and physical, are conditions favorable to the commission of offenses against the public". As a result, we shall examine all offenders, and those having disease or defect will be either cured or placed where they will no longer menace society. Most of our crime is not a necessary evil.

The author points out that many universal traits are more or less antisocial and must be controlled for the benefit of society, since the group is more important than the individual. If the individual fails in such control because he cannot understand (feeblemindedness), or because he lacks the ability to control (mental disease and psychopathy), he must be cared for medically, not legally as at present.

The chapter *The Psychopathic Child* is most interesting and instructive. The necessity of differentiating between feeblemindedness and psychopathy is clearly stated. "Psychopathic children differ from the feebleminded in that the former are diseased, while the latter simply have not developed." There is an excellent description of the psychopathic child. It is claimed that it is possible by psychological tests to diagnose psychopathy easily, and to distinguish normality, psychopathy, feeblemindedness, and psychopathic feeblemindedness, each from the others. The psychological test is spoken of as "an X-ray picture of the mind". This seems a fair comparison to the reviewer, since both psychological tests and X-ray examinations, even in the hands of experts, often fail to show diseased conditions and frequently show abnormalities that do not exist.

As to the causes of psychopathy, we are told that "a surprisingly large proportion of delinquency is due to congenital syphilis". Other causes given are fevers, infections and intoxications, "disturbance of the emotional system, which of course may act through the glands of internal secretion affecting the blood stream and thus the brain itself", and pushing ahead too fast "exceptionally bright children". As regards syphilis as a cause of psychopathy, it is stated that "enough is already known to make it reasonably safe to conclude that when there is syphilis in the parents and persistent bad conduct in the child, we are dealing with cause and effect". The reviewer feels that such a conclusion is illogical and that it is not fair to conclude that bad conduct in the child of syphilitic parents is necessarily caused by other conditions than those that cause bad conduct in children whose parents are not syphilitic.

The author frankly admits that but little progress has been made in the direction of treatment. The most important thing is the plac-

ing of all such cases under medical supervision until they are cured, and the folly of the present system of punishment by confinement for a stated period is clearly shown. As the author aptly remarks, one might as well commit an insane person for a period of one year as a delinquent.

The schools are rather caustically criticized. The author states that "the first business of schools is to socialize the child", render him fit to live in society, rule improper instincts, and teach him honesty and morality. No child whose intelligence is less than twelve years can understand abstract principles. Hence the schools will never socialize children with their present methods of teaching abstract principles to those of low intelligence.

There are several chapters given to an interesting account of the bureau's work in Ohio, and statistical tables and case histories are furnished.

The reviewer believes that undue emphasis is placed on congenital syphilis as a cause of delinquency, and he also feels that the author overemphasizes the value of formal psychological tests. However, the book on the whole is a welcome addition to the study of delinquency. It states clearly and concisely many important facts concerning delinquency and points the way to a more desirable method of treating this condition.

Karl M. Bowman.

Boston Psychopathic Hospital.

Readings in Evolution, Genetics, and Eugenics. By Horatio Hackett Newman, Professor of Zoology, University of Chicago. Chicago: The University of Chicago Press, 1921. 523 p.

The author has succeeded in presenting a very readable, non-partisan account of our present knowledge of evolution, genetics, and eugenics. For a general survey in this field we know of no better work, and the book ought to receive wide recognition as a dependable source book. One's pleasure in reading the book is very much enhanced by the extensive quotations from the original writings of the fathers of these sciences.

Bernard Glueck.

New York School of Social Work.

Von Seelischen Gleichgewicht und Seinen Störungen. By Dr. Walter Gut. Zurich: Art. Institute Orell Füssli, 1921. 163 p.

This little volume consists of five popular lectures on mental equilibrium and its disorders, delivered by the author during the spring of 1920. The chapter headings are as follows:

1. *Mental Disorders on the Basis of Bodily Defects.*
2. *Disorders Based on Neurotic Disposition and Certain Types of Mental Constitution.*
3. *Disorders in the Developmental Career of Normally Constituted People.*
4. *Mental Disorders in the Individual as an Expression of the "Maladies of the Times".*
5. *On Mental Health.*

The author states in very clear and simple language the modern tendencies in psychopathology, and his contribution is thoroughly dependable.

BERNARD GLUECK.

New York School of Social Work.

AN INTRODUCTION TO CHILD PSYCHOLOGY. By Charles W. Waddle. Boston: Houghton Mifflin Company, 1918. 317 p.

The outstanding merit of this little volume lies in its clear and attractive presentation of the fundamental movements in scientific child study, experimental pedagogy, and behavior. It is conservative in that it all but ignores any contributions of the analytic schools in its otherwise very admirable survey and bibliography.

The topics for discussion accompanying each chapter are splendidly provocative of thought and greatly enhance the value of the book. There is fairly ample treatment of biological considerations, with a thoroughly satisfactory digest of fact and fable in mental inheritance.

The chapters on the moral nature of children and juvenile delinquency summarize the recent statistical studies in ownership, destructiveness, truancy, lying, obstinacy, teasing, bullying, and general incorrigibility, passing over with inadequate mention the subject of sex delinquencies.

As a resumé it is a very useful addition to the textbooks in child study, although it makes no pretense of offering original material or of being a comprehensive treatise.

MARION C. GOULD.

Vassar College.

EXCEPTIONAL CHILDREN AND PUBLIC SCHOOL POLICY. By Arnold Gesell, M.D. New Haven: Yale University Press, 1921. 66 p.

The author of this monograph is, if the reviewer mistakes not, the first university professor in this country to hold a chair devoted to child hygiene, and is also a well known specialist in mental hygiene. From such a well-equipped authority the reader expects a trustworthy and significant contribution, and he is not disappointed.

Dr. Gesell discusses the place and importance of mental hygiene in the public school and the question when is a school child exceptional. He notes that "humanity as well as hygiene requires that we recognize at least the most radical individual differences among our school children"; and in answer to the question when we should regard a child as "educationally exceptional", borrows the phraseology of the law and replies "an exceptional school child is one whose mental or physical personality deviates so markedly from the average standard as to cause a special status to arise with respect to his educational treatment and outlook".

The results of an important mental survey of 24,000 school children in the New Haven schools, from the kindergarten to the eighth grade inclusive, are presented. The children were classified as: (a) definitely backward; (b) very probably deficient; (c) doubtful; (d) merely backward.

Among a total number of 725 children reported under these rubrics, 270 cases of mental deficiency were found; and an examination of the school problems of these children "gives convincing evidence of the subnormal intelligence with which the school is obliged to deal". A series of graphs show the age distribution of these deficient children and reveal the following facts:

> "71 children over 8 years of age cannot describe a simple picture;
> "66 children over 8 years of age cannot copy a diamond;
> "31 children over 7 years of age cannot read at all (only 39 out of 270 read fluently or with expression; the remainder read imperfectly, syllabically, haltingly);
> "95 children, ranging in age from 9 years to 16 years, cannot write their whole name;
> "126 children do not respond correctly to the simple question, 'In what city do you live?'
> "109 children, ranging in age from 10 years to 16 years, cannot tell time."

Among other subjects considered are superior and atypical mentality, the relation between social status and intelligence, different types of exceptional children, school provisions for mentally deficient children, vocational training, proposed legislation, and the Connecticut Children's Code, which emphasizes the principle of local community responsibility and "the dependency of this principle upon adequate state organization and authoritative state supervision".

What happens to these subnormally minded children when they leave school, Dr. Gesell was unable to say with statistical accuracy. But he adds: "We may be certain that it is these very subnormal children who as youths and as adults may pile up for society a large burden of inefficiency, crime, vice, and dependency. It is always well to remind ourselves that our future social problems are concretely foreshadowed in the children who are now making a failure of school life—the children revealed by our mental survey."

William H. Burnham.

Clark University.

Child Welfare from the Social Point of View. By Nora Milnes, B.Sc., Director of the Edinburgh School of Social Study. London and Toronto: J. M. Dent and Sons, Ltd. New York: E. P. Dutton and Company, 1921. 243 p.

Every mental-hygiene worker, as well as every other kind of social worker, would probably agree with feeling with what Miss Milnes says about the relationship of social worker to physician. Until recently, she states, infant welfare has been regarded as a medical rather than a social question, but now it has very definite social aspects. "The person with an exclusively medical training can no more expect to tackle a social question unaided than a person with an exclusively social training can be expected to recognize and tackle the symptoms of disease. . . . The ordinary social worker may be painfully aware of his ignorance of medical questions, yet he may sometimes be led to wish that the medical specialist were as equally aware of his ignorance of the great social factors." She comments that just as the medical man has resented the intrusion of non-medically trained social workers into a field formerly exclusively medical, so, too, social workers now are finding it annoying that workers with no knowledge of or training in social work are dealing with questions evidently social. She is quite right. Social workers are becoming in their way as much a necessity as nurses to physicians, and yet physicians are unversed in the technique of social workers and do not meet them halfway. It is a pity that Miss Milnes does not urge that at least as much instruction be given in medical schools in regard to social problems as social workers get in lectures on medical subjects. Incidentally, it is likely that education of social workers will eventually result in education of the laity, sufficient ultimately to force medical schools to give some teaching with regard to social problems that are allied to the health of individuals and groups. This, however, digresses from Miss Milnes' book.

This book's scope is not broad, dealing with the dependence of the child upon such environment as money can buy. Miss Milnes says: "It is but too evident that poverty lies at the root of the whole problem that gives rise to the child-welfare movement." She regards the study of child welfare as one of applied economics, arguing that the whole science of economics is concerned with the examination of forces that are at work aiding or hindering man in his efforts to satisfy his wants, and that the social worker is usually concerned with helping to satisfy wants that otherwise would remain unsatisfied. The practical aim of the child-welfare movement she separates into two branches, the first being to reduce the infant-mortality rate, and the second to afford to the child a better chance to develop into a healthy adult. Although Miss Milnes feels that it is hardly to be expected that those will succeed in life who have had insufficiency of fresh air, good food, warmth, rest, play, and education, and who have lived in "sordid, material surroundings, ugliness unrelieved", she would have us hope that "all this we may try to tackle by dealing with the outer environment". She says nothing about child welfare among the well-to-do, though there is many a Poor Little Rich Girl besides the one Eleanor Gates portrayed. Would Miss Milnes say that the wealthy have no need of social workers?

In her chapter on the mother, she never pictures the mother of a large family happy, though poor, but always the mother who, although with no actual physical deterioration due to child-bearing, becomes nevertheless a drudge with lowered mental capacity and an irritable temper; "with no one to relieve her, no pleasure before her except those that are born of her maternal instincts, she not unnaturally becomes ill-tempered, nervy, and in every way unfit for her task". The author believes that the mother's irritability will make the child "shy, nervous, or even untruthful, . . . and since these factors are as important as the physical, then in our educational efforts it behooves us to do all we can to keep the mothers' outlook bright, cheerful, and alive".

Possibly Miss Milnes does have in mind the relationship of mental outlook and contentment to child welfare, but she gives it no space in her book. She would furnish contentment by external means. Many people believe every tub rests on its own bottom and that contentment must come from within oneself before real enjoyment can take place in one's environment.

A few times in the book, Miss Milnes very briefly mentions phases of the mental side of life. In one instance, she speaks of children being sensitive to injustice and unable to comprehend the attitude of the

adult; in another, she barely mentions the possibility of a child's joining the ranks of juvenile delinquents if he has been too much disciplined; and in another, she refers to the standard of morality a child is apt to have if brought up in a one- or two-room dwelling "in close contact with the grossest materialism". These are mere statements and are not dealt with, though many readers of MENTAL HYGIENE would consider them to be of as much importance to child welfare as are housing, food, and clothing.

Miss Milnes deals with the subject of child welfare entirely in its relation to economics. She does not mention mental diseases such as psychoses, neuroses, or feeblemindedness, and does not account for the existence of poverty in any other way than by conditions existing outside the individual. All those who have no training in economics would do well to read Miss Milnes' *Child Welfare,* but those interested in the mental welfare of a child will not find their wants satisfied in this book.

THADDEUS H. AMES.

New York City.

WILL POWER AND WORK. By Jules Payot, M.D. Translation by Richard Duffy. New York and London: Funk and Wagnalls Company, 1921. 422 p.

In reading this book, one is immediately impressed by the fact that it was written by a person who was not dealing with theories, but writing of what he knows. It might be called a practical technique of thinking. It describes the proper way to work, and instructs one in the importance and the best methods of using the mental faculties of attention and memory. The last two paragraphs of the translator's introduction well express the purpose of the book:

"In earlier days progress in the world was slow and painful because there was so much ignorance in all countries. Nowadays, as humanity strains and tugs feverishly to advance, it finds its chief obstacle to be the friction and hindrance caused in the general mind of the world because the great majority are partly educated or are over-educated.

"To supplement the education that is lacking, and to render assimilable the education that causes chronic mental indigestion, is the purpose of this book. It is designed to achieve that purpose, not through any mysterious and occult procedure, but through forthright expression of ideas, which he who reads may understand as he reads, and be guided to the knowledge that insures broadening and deepening of the mind as well as invigoration of the soul."

Dr. Payot has succeeded in producing a most useful and interesting work. Many educators would profit through reading it, and if a copy of it were to be placed in the hands of every college matriculant, the educational machines would turn out better educated individuals. This book needs to be read only once to be appreciated, but it deserves the careful study of every student who is searching for a practical technique of acquiring knowledge.

William B. Terhune.

Connecticut Society for Mental Hygiene.

How the Mind Cures. By George F. Butler, M.D. New York: Alfred A. Knopf, 1921. 286 p.

This is the story of a business man who in many respects is maladjusted, and of a doctor who attempts to reëducate him. It is written in dialogue form, and purposes to be a record of the conversations of the physician and the patient. The latter is a man of narrow interests, such as are encountered daily in many walks of life, and the doctor is a psychiatrist with an acceptable, if simple, philosophy of living which he succeeds in imparting to the patient. The book stresses the importance of fresh air, proper food, exercise, rest, seeking pleasure in work, and self-control. People of limited education will find it helpful, while those who have received a high-school training may be assisted through the reiteration of facts with which many of them are already familiar.

Dr. Butler is to be congratulated, in as much as he has written a book that will not suggest symptoms to the most suggestible patient.

William B. Terhune.

Connecticut Society for Mental Hygiene.

Mental Development and Education. By M. V. O'Shea. New York: The Macmillan Company, 1921. 403 p.

Many readers of Mental Hygiene will remember the wholesome influence upon education of O'Shea's *Dynamic Factors in Education*, published nearly twenty years ago. *Mental Development and Education* has been written to take the place of the former book and, although nearly all new in material, it is in the spirit of its predecessor. It is primarily for teachers and will surely prove popular and useful. It abounds in concrete material and is measurably richer in substance than O'Shea's first book. It nevertheless reveals in places a lack of knowledge of recent psychology. The discussion of fear as a motive force in development is an illustration of this fact.

Ernest R. Groves.

Boston University.

Psychology and the School. By Edward Herbert Cameron. New York: The Century Company, 1921. 339 p.

Psychology and the School is written for students and teachers who have no previous knowledge of psychology. It presents in a clear, concise manner the type of educational psychology that has been built upon the psychology of a decade ago. Little reform in school practices can be expected until the meaning of recent studies in human behavior can be interpreted to teachers in an educational psychology that utterly discards the structural treatment of psychic experiences.

Ernest R. Groves.

Boston University.

Applied Psychology for Nurses. By Mary F. Porter. Philadelphia: W. B. Saunders Company, 1921. 172 p.

This book is written simply and for the general nurse; its contents justify its title. If it is touched by a New Thought phraseology in spots, this is in a laudable effort to emphasize older and valuable ideas. "I conceive of it as possible that every well-trained nurse in our country shall consider it an essential to her professional success to leave her patient imbued with the will to health and better equipped to attain it because the sick attitude has been averted." The general nurse is addressed, and the general patient is the subject, in contrast to Dr. Burr's *Practical Psychology and Psychiatry,* which addresses nurses and doctors on the subject of the psychiatric patient.

The consciousness of the normal person is considered in three chapters and the "normal mind" in three more. Consciousness is the "simplest mental reaction to what the senses bring", and the "unconscious is simply the latent conscious—what once was conscious and may be again, but is now buried out of sight". Throughout these chapters occur many similes that give clarity, perhaps, but that tend to inexactness. The sympathetic nervous system is "the direct connecting link between mind and body", and the wise nurse "soon realizes that this system, rather than physical disability, causes many indigestions, headaches, diarrheas, dry mouths, chills; is responsible for much nausea, much exhaustion". Here the writer warns the nurse not to decide whether the disorder is of nervous or physical origin, but to become expert in reporting all sorts of symptoms. The mind is divided up in the conventional way—memory, ideation, etc., with the usual explanations.

In the chapter *Psychology and Health,* the author gives "*adaptability, suggestibility, attention, thought-substitution, habit-formation,* and *will*" as functions of the mind that can influence health. She discusses the self-deceivers, the dreamers, and the important fact

that tendencies to mix the unreal with the real are constantly met in all surgical and medical patients. She urges the nurse to eliminate all unnecessary irritations while helping the patient to face squarely, and adjust himself to, the inevitable. The value of using the hypersuggestibility of almost all sick people to help them is very well put; the art of inspiring confidence, of saying things in the pleasant way, of a drive to substitute new ideas for dismal worrying over symptoms, is described in acceptable terms. "The nurse who can direct attention to other people, to analyzing the sounds of the street, to understanding something of the new life of a hospital or sick room, . . . to current events, . . . a picture, etc., is fixing the patient's attention on something constructive." It is encouraging to see that the nurse must not adopt a "patent, blatant, hollow cheerfulness" and must not let the patient get too dependent.

In opening her discussion of variations from the normal, the author uses a classification that the reviewer cannot follow. Disorders of ideation, reason, and judgment are hard to separate, and it is of doubtful benefit to say that "every departure from the normal mind attitude tends to associate itself with one of the following five states of mental disability: depression, exaltation, perversion, enfeeblement, deficiency."

The definitions that follow are sometimes clear and sometimes excusable because of the audience to whom they are addressed and the principle that every one has a right to his own opinion as to what a term should mean.

The rest of the book gives to the nurse several practical suggestions: how to divert the patient's mind from an immediate want; how to make the goal of health desirable; how to submerge her own preoccupations in her interest in her patient; how to bring interesting, but not too numerous, things to the patient's mind; how to try to get the patient's point of view; and how to carry on in a normal, purposeful way in the face of strongly held delusions. And the book ends by pointing out to the nurse the ways of becoming accurate and of controlling emotional responses. It is rather breath-taking to learn that the nurse of the future will "know the laws of mind as she knows the course of disease" and "will be a sworn, trained ally of the health-accepting mind".

E. D. Bond.

Pennsylvania Hospital.

NOTES AND COMMENTS

Connecticut

A department of public welfare was created by Chapter 307, Laws of 1921. It is the successor of the state board of charities. This department is to organize two bureaus, one to be known as the bureau of adult welfare and the other as the bureau of child welfare. The former is to perform duties heretofore imposed upon the state board of charities. The department is to appoint a secretary, a commissioner of child welfare, one deputy, and supervisors. The commissioner shall have general supervision over the welfare of children who require the care, protection, or discipline of the state. No person may care for more than two dependent, defective, delinquent, or neglected children without first having obtained a license from the department. Licenses are granted by the department upon the recommendation of the commissioner of child welfare. He is to be the chief juvenile-court probation officer of the state and may supervise the probation officer of such courts and assist such courts in their work.

Chapter 336, Laws of 1921, relating to juvenile courts, provides that prior to the hearing of the case of any alleged delinquent child, the court shall, if practicable, cause him to be examined as to his mentality by a competent and experienced mental examiner, who shall make a report of his findings. Whenever a child brought before the court shall be found to be mentally defective, the court may order his commitment to an institution for mental defectives or defective delinquents, or may order him placed on vocational probation. In the latter case, he is given suitable employment and supervised by a probation officer.

By the terms of Chapter 355, Laws of 1921, upon the petition, approved by the state board of education, of the parents or guardians of ten or more educationally exceptional children residing in any school district, the board of school visitors, town school committee, or board of education must establish a school for such children or provide otherwise for their instruction. The term "educationally exceptional children" includes all children over four and under sixteen years of age, who, because of mental or physical handicap, are incapable of receiving proper benefit from ordinary instruction, and who need special educational provisions.

Chapter 265, Laws of 1921, requires a mental as well as a physical examination before the commitment of a child to a county temporary

home. It contains the following provision: "In all cases where the court to which petition is brought for commitment of a child to a county temporary home is situated within fifteen miles of a duly recognized clinic in mental hygiene or institution for the treatment of mental diseases or professional office of a responsible alienist or expert in psychiatry, said court shall, before the hearing is held on the petition, require a mental examination to be made of the child concerned in such petition by such responsible alienist or by an expert connected with such clinic or institution as heretofore described, who shall be appointed by the court for this purpose, provided, in case the town is more than fifteen miles from a duly recognized clinic, the examination shall be made by a reputable physician."

District of Columbia

In the appropriation bill for the District of Columbia for the fiscal year ending June 30, 1923, there is an amendment authorizing the commissioner of the district to acquire a site for an institution for feebleminded persons. This institution must be located in the District of Columbia, Maryland, or Virginia, and is to be constructed at a cost not to exceed $300,000. This amendment was adopted by the United States Senate, but at the time of going to press, the House of Representatives had not acquiesced in it.

Georgia

A bill will be introduced in the 1922 legislature, which convenes in June, to establish a state department of mental hygiene. This department would be charged with the control and administration of the state hospital for mental diseases, the state school for mental defectives, and any other state institutions for the care of these patients that may hereafter be established.

Idaho

A new reception building has been opened at the state hospital, at Blackfoot.

Illinois

A new building for the physically ill has been completed at the Elgin State Hospital. This building accommodates 80 patients and has suitable quarters for ill employees. It has isolation wards for contagious diseases, a dental office, an X-ray laboratory, an eye, ear, nose, and throat room, a minor surgical room, a pharmacy, and a clinical laboratory. A similar hospital building is under construction at the Alton State Hospital and the construction of one at the Dixon State Hospital will soon be started.

Indiana

Plans have been drawn for fourteen new cottages at the Indiana Village for Epileptics, at Newcastle.

Louisiana

Contracts have recently been awarded for the construction of four new buildings at the state hospital for mental diseases located at Pineville. Three of these buildings are to be dormitories, each to accommodate 110 patients. The fourth will contain a dining hall and assembly room.

Maryland

A state reorganization law that has been enacted by the 1922 legislature divides the administration of the state government into nineteen departments. One is the department of welfare. At the head of this department is a board of welfare, consisting of the director of the department, who is to serve as chairman of the board, and four associate members. They are to be appointed without regard to political affiliation, must be not less than thirty years of age, interested and preferably experienced in social welfare, and at least one associate member must be a woman. There is to be a board of mental hygiene in this department, consisting of the commissioner of mental hygiene, who shall serve as chairman of the board, and six associate members. The commissioner must be a qualified physician with at least five years' experience in the treatment of mental diseases. Of the associate members, at least three must be appointed from the city of Baltimore, and at least four shall be graduates of some legally authorized medical college and have practiced their profession for at least five years consecutively just preceding their appointment. The board of mental hygiene is the successor of the state lunacy commission, and assumes all the rights and obligations of this commission.

Minnesota

A research bureau in mental deficiency has been established by the state board of control. The functions of the bureau are as follows: To make all examinations in mental deficiency in connection with commitment of persons to institutions; to conduct a mental clinic at its office in St. Paul, and such other clinics in the state as circumstances may permit; to make other investigations concerning mental deficiency that may aid the board of control in the management of its institutions. This bureau is under the direction of Dr. Fred Kuhlman, formerly head of the research department of the Minnesota School for the Feebleminded.

Missouri

By the terms of a law enacted by the last legislature, special classes in the public schools are provided for children who are not feeble-minded, but are on the border line of mental deficiency, or those who are so backward as to be incapable of receiving proper benefit from instruction in the regular grades. School districts may establish such classes for 20 or more children, and shall receive state aid to the amount of $300 per year for each teacher thus employed. When there are 50 or more children with speech defects in any school district, they may receive special instruction. Such children need not be segregated into special speech classes, but may be taken aside, singly or in groups, during certain periods for speech-corrective training. In 1919, this state enacted a law authorizing special classes for mental defectives in the public schools.

New York

An amendment to the education law has been enacted that establishes a department of extension teacher training in the State Normal School at Geneseo, under which is to be placed the regular school work at the Craig Colony at Sonyea. This law confirms a working arrangement that has been successfully in operation for several years.

A bill that would authorize the appointment of a commission to select a site for a state school for mental defectives in western New York has failed.

An amendment to the insanity law has been approved that directs magistrates in New York City, upon the request of the director of the United States Veterans' Bureau, to commit for observation alleged insane veterans brought before them to the new veterans' hospital in the Bronx. It also authorizes the state hospital commission to transfer veterans of the World War from a state hospital to the veterans' hospital.

Assembly Bill 498, which would provide for trial by jury to determine the question of insanity, failed of passage.

An amendment to the insanity law permitting the medical superintendent of the Matteawan State Hospital to transfer any convict before or after expiration of sentence, who is a mental defective, to the state institution for defective delinquents at Napanoch, has been passed, and also an amendment to the prison law allowing the board of parole for state prisons to parole a male convict to this institution,

and a female convict to the division for defective delinquents at the Bedford Reformatory.

The governor has approved Assembly Bill 139, providing for another civil state hospital to be known as the Brooklyn State Hospital, Creedmoor Division. The sum of $2,979,782.76 has been appropriated, being the unexpended balance of the three million dollars appropriated by Chapter 958, Laws of 1920. This law has grown out of the bills for a military hospital on this site.

The 1922 Appropriation Bill, which has been approved, grants $1,989,600 for new construction and improvements at the state hospitals and a special appropriation of $13,700 for developing occupational therapy. It also allows for five additional social workers.

North Carolina

Contracts have been awarded for the construction of three new buildings at the State Hospital, at Morganton, including a dormitory for men, a house for staff members, and a central kitchen. The total cost of these buildings will be about $100,000.

North Dakota

Chapter 64, Laws of 1921, authorizes parole of the feebleminded from the state institution. It also contains the following provision: "The superintendent may admit to the institution temporarily, without commitment, under such rules and regulations as the board of administration may prescribe, for purposes of observation, such children or adults as are suspected of being feebleminded or idiotic, to ascertain whether or not such person is actually mentally defective and a proper case for care, treatment, and training in an institution for the feebleminded."

Ohio

An administrative code, enacted by the 1921 legislature, divides the administrative functions of the government into the following departments: finance, commerce, highways and public works, agriculture, health, industrial relations, education, and public welfare. Each department has at its head a director who is appointed by the governor with the advice and consent of the senate. There is an assistant director in each department, who must be designated by the director to fill one of the offices created in the department or as the head of one of the divisions created in the department. When a vacancy occurs in the office of the director, the assistant director is to act as

director until the vacancy is filled. The department of public welfare has jurisdiction over the following institutions: state hospitals for mental diseases and Longview Hospital, state institutions for epileptic, feebleminded, deaf, or blind persons, state sanatorium, soldiers' and sailors' home, state industrial schools, penitentiary, reformatories, and prison, and the bureau of juvenile research. The following offices are created in this department: fiscal supervisor, superintendent of charities, and superintendent of pardon and parole. The department of public welfare has all the powers and duties of the board of administration, which is abolished by this act, excepting the power to purchase supplies for the support and maintenance of state institutions. This power is now conferred upon the department of finance. The department of public welfare also has all the powers and duties of the former board of state charities and the board of clemency.

Pennsylvania

Act 208, Laws of 1921, requires that all persons sentenced to serve a term in any jail or penal institution be examined as to physical and also mental condition, within forty-eight hours after admission. This law also authorizes that prisoners who are not mentally normal be segregated from the others.

Act 166, Laws of 1921, provides for the service of process upon the next of kin, in the commitment of an insane person, whenever the court believes this procedure to be in furtherance of justice and for the benefit of the person.

The name of the "Pennsylvania State Lunatic Hospital" has been changed by law to "Harrisburg State Hospital". When this hospital was established in 1845, it was called "The Pennsylvania State Lunatic Hospital and Union Asylum for the Insane."

South Carolina

A bill has been introduced in the 1922 assembly that would require the board of trustees of any school district to provide annually for a medical, mental, and dental inspection of all pupils attending the public schools.

Another bill would give to the state board of public welfare supervision of mentally defective children who are in their own homes, and would authorize this board to visit such children and advise their parents or guardians with reference to their care and training.

A third bill, providing for the instruction of mental defectives in

special classes in the public schools, reads as follows: "Whenever in any school district there are as many as ten mentally defective children of school age, the board of trustees of the said school district shall provide a teacher who shall have no other duties than those of instructing the said mentally defective. Provided that when there are more than ten mentally defective children in any school district, the said district may provide for more than one class. The salary of said teacher or teachers shall be paid by the said school district and the state board of education, each paying one half."

Another bill would require the examination of juvenile delinquents by psychiatrists or psychologists. This bill provides, in the case of any person under the age of eighteen years brought before any magistrate, judge of probate, court of general sessions, municipal court, or any other court having original jurisdiction in the trying of persons charged with violation of any criminal law of this state, that the court shall examine into his mentality. If it appears that the person is not normal mentally, then the court shall remand him back to custody and shall request the state hospital to send a psychiatrist, or the state board of public welfare to send a psychologist, whichever the court may elect, to examine the mind of this person. After the psychiatrist or the psychologist has made an examination, he shall then report to the court the findings.

The above-mentioned bills are in accordance with recommendations made by The National Committee for Mental Hygiene, as a result of a survey of the state that has recently been completed.

Vermont

A law enacted by the 1921 legislature authorizes the supervisors of the insane to detain, for observation for a period of not more than twenty days in any hospital of the state, insane residents of this state who have been apprehended and adjudged insane in another state or country and have been returned to this state. Upon petition brought before any probate court in the state during this period of observation, the supervisors may have such persons committed to the state hospital at Waterbury or the Brattleboro Retreat.

West Virginia

By Chapter 135, Laws of 1921, a state child-welfare commission has been created. The purpose of this body is to study and investigate the laws and conditions in the state relating to dependent, neglected, defective, and delinquent children. The commission is to report the results of its investigation to the next legislature together with its recommendations.

A law enacted by the 1921 legislature, relating to commitment of persons to the industrial home, contains the following provision: "Before committing a girl to the industrial home, the justice, or other authority committing her, shall cause her to be examined by a reputable physician, who is authorized to practice medicine in this state, in order to ascertain whether such girl is sound in mind, and whether or not she is an imbecile or an idiot, or is pregnant, or afflicted with epilepsy, syphilis, gonorrhea, or any other infectious or contagious disease, and as to any other particulars that may be prescribed in the rules and regulations of the state board of control."

Canada

A new building for acute mental cases has just been completed at the Hospital for Mental Diseases, at Selkirk, Manitoba. This building has a capacity of 65 beds.

A training school for mental defectives has been constructed at Portage La Prairie with accommodations for 50 patients. This institution is arranged on the colony plan and 15 additional buildings are contemplated.

A psychopathic hospital has been constructed at Winnipeg that accommodates 40 patients.

A number of new buildings are to be constructed at the Hospital for Mental Diseases, at Brandon. A building for acute mental cases is to be built to accommodate 100 patients. Four units on the colony plan for chronic cases are to be constructed about one mile from the main building. These units will together accommodate 250 patients. One of these units with a capacity for 80 male patients has been completed. A nurses' home has recently been constructed at the hospital.

The National Conference of Social Work

The Forty-ninth Annual Meeting of the National Conference of Social Work will be held in Providence, Rhode Island, June 22-29. The following program has been announced for the Mental Hygiene Division:

Section Meeting I

Extramural Management of Mental Defectives.

1. *The School's Part in Developing an Effective Program.*
2. *Coördinating the Functions of the State and the Community into an Effective System.*

SECTION MEETING II

Teamwork in Mental Hygiene.

1. *A State Program of Mental Hygiene.*

SECTION MEETING III

Mental Hygiene as a Vital Factor in Education.

1. *The Function of the College in Promoting Mental Hygiene.*
2. *Coöperation between the Mental-Hygiene Movement and the Educational Program.*

SECTION MEETING IV

Mental Hygiene of Childhood.

1. *The Clinician's Opportunity.*
2. *The Social Worker's Opportunity.*

SECTION MEETING V

1. *Results and Further Opportunities in the Field of Clinics, Social Service, and Parole.*
2. *The Community's Responsibility in Promoting the Mental-Hygiene Movement.*

The program for the Division on Health includes papers on *Health and Medical Work in Department Stores, The Program of the American Association of Physicians in Industry, The National Health Council and Common Service Committee,* and *Social Hygiene and Venereal Disease Control.*

Among the topics of special interest that will be taken up at the general-session meetings are *The Family as a Factor in Social Evolution, Neglected Fundamentals in Children's Work, The Lawbreaker and Needed Improvements in His Treatment,* and *Underlying Concepts in the World Movement for Health.*

MENTAL HYGIENE AND THE LAW

In an article on the progress of the law during 1921, Professor Chafee, of the Harvard Law School, says regarding certain phases of interest to mental hygienists:

"Reform in the methods of settling questions of mental capacity is urged, not only by lawyers, but by alienists, psychiatrists, and psychologists. Henry W. Taft speaks for the bar in voicing dissatisfaction with medical experts in will cases.[1] Dr. W. A. White, Superintendent of the Government Hospital for the Insane, Washington, D. C., writing on *Expert Testimony in Criminal Procedure Involving the Question of the Mental State of the Defendant,*[2] recommends a statute drawn by the American Institute of Criminal Law

[1] *Comments on Will Contests in New York,* 30 *Yale L. J.* 593, 601 (1921).
[2] *J. Crim. L. & Crim.* 499 (1921).

and Criminology, which authorizes the court to summon experts who may be questioned by both sides; allows the defendant to be examined by these experts and by the state's experts; sends the defendant to a hospital for observation, where all experts shall have access to him; directs each expert to prepare a written report on which he may be cross-questioned, as a substitute for the discredited hypothetical question, which is to be abolished; and also authorizes all the experts, if they see fit, to prepare a joint report. The appointment of experts by the court, which need not be limited to mental experts or to criminal cases, is also recommended by a committee of the Board of Circuit Judges of Wisconsin. Their report, by Judge E. Ray Stevens,[3] reviews the statutes of the states which already allow such experts and submits a draft statute. It is to be hoped that the Michigan decision [4] invalidating such a statute on the ground that the selection of witnesses is not a judicial act represents the isolated attitude of a court which has shown itself noticeably inhospitable to modern legal methods.[5] The value of mental examinations of defendants in criminal cases and of juvenile delinquents has been well proved.[6] It suggests the possibility of similar examinations of witnesses of alleged mental defectiveness or psychopathic tendencies.[7] Although the law has refused to admit lay evidence that a witness' mentality is low,[8] except when it approaches insanity, because such evidence is too uncertain, the report of a Binet-Simon or other intelligence test would be of distinct value to a trained judge in weighing testimony, and attempts to introduce such reports have recently been made.[9] Undoubtedly the wide use of such tests in the army will have its in-

3 *Expert Testimony*, 10 *J. Crim. L. & Crim.* 188 (1919). See also G. W. Jacoby, *The Unsound Mind and the Law*, 1918; reviewed in 33 *Harv. L. Rev.* 881.

4 People *v.* Dickerson, 164 Mich. 148, 129 N. W. 199 (1910).

5 Anway *v.* Grand Rapids Ry. Co., 211 Mich. 592, 179 N. W. 350 (1920)—declaratory judgments invalid; Wattles *v.* Upjohn, 211 Mich. 514, 179 N. W. 335 (1920)—proportional representation invalid; Atty. Gen. *ex rel.* Dingeman *v.* Lacy, 180 Mich. 329, 146 N. W. 871 (1914)—Detroit court of domestic relations invalid.

6 See, for example, T. W. Salmon, *Some New Problems for Psychiatric Research in Delinquency*, 10 *J. Crim. L. & Crim.* 375 (1919); H. Olson, *The Psychopathic Laboratory of the Municipal Court of Chicago*, 92 *Cent. L. J.* 102 (1921).

7 Tom A. Williams, *Some Remarks about Testimony* (summarized from the experience of French psychiatrists and experts in legal medicine), 10 *J. Crim. L. and Crim.* 609 (1920); see also 64 *Sol. L. J.* 579 (1920).

8 Bell *v.* Rinner, 16 Ohio St. 45 (1864).

9 State *v.* Wade, 113 Atl. 458 (Conn. 1921), after use of Binet-Simon reports of the defendant's mentality, similar reports on witnesses were excluded by the trial court; held within its discretion, as a question of remoteness. These tests were applied to the defendant in State *v.* Schilling, 112 Atl. 400 (N. J., 1920.)

fluence. The difficulty is, however, that these tests of a witness will go, not to a judge, but to the jury. Hence their value is much less than for the juvenile delinquent, who gets no jury trial. The defendant in a criminal case is also likely to be a better subject of intelligence tests than a witness, if the criminologists succeed in their plan to have the jury pass only on the question whether the accused committed the criminal act with *mens rea*, leaving his mental responsibility and his subsequent treatment, whether in a prison, asylum, or hospital, to be determined by a board on the basis of expert recommendations. The mental capacity of a witness will always have to be left to the jury, so long as there is a jury to determine the issues of fact on which this witness testifies, and it is doubtful whether such a rough-and-ready instrument of justice can cut to the fine lines involved in an intelligence test. W. M. Marston,[10] of the Massachusetts bar, has experimented with blood pressure and other tests to determine the veracity of witnesses, and states that the results of these tests were corroborated by the subsequently disclosed facts, already known to the witness. Lawyers will await the results of such investigations with open minds. They cannot, of course, be substituted in courts generally for present methods of examination until their usefulness is thoroughly demonstrated. If such tests ever are adopted, it is probable that the jury system will have to be abandoned, unless education will have advanced so far that twelve men picked at random will adequately absorb blood pressures, time reactions, and intelligence quotients, and combine the mass into a just verdict. In other words, the jury might also be subjected to an intelligence test."

10 *Psychological Possibilities in the Deception Tests*, 11 *Crim. L. & Crim.* 551 (1921).

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MENTAL HYGIENE

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SOME ASPECTS OF MENTAL HYGIENE*

PRESIDENTIAL ADDRESS, SECTION OF PSYCHIATRY, ROYAL SOCIETY OF MEDICINE

E. FARQUHAR BUZZARD, M.D., F.R.C.P.

Physician to St. Thomas' Hospital and the National Hospital for the Paralyzed and Epileptic

THE occupation of a presidential chair by one to whom the experience is new and unexpected cannot fail to have serious consequences on the mental attitude of the occupant. His sense of inferiority is unpleasantly aroused by looking back at the names of his predecessors in office, while his sense of reverence for presidents in general, a habit of mind that has grown with increasing years, is in danger of destruction. My pride in the honor that has been bestowed upon me is justly tempered by the knowledge that I owe my position, not to individual merit or to eminence in psychiatry, but to the graceful and generous tribute paid from time to time by the members of this section of the Royal Society of Medicine to their neurological brethren. This symbol of the cordial relationship between psychiatrists and neurologists is peculiarly happy in its appearance at the present moment. The borderland that separates and yet unites our respective territories has for some years past been the scene of an invasion by a somewhat heterogeneous multitude of students, the large majority of whom claim to be disciples of Freud and Jung. These invaders have sprung not only from the ranks of psychiatry and neurology, but in many instances have wandered from more distant realms of medicine and of science. As was inevitable in an unorganized movement of this kind, those

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taking part in it have not all been equally well armed. Some have lacked sufficient training in psychiatry and neurology, while others have been deficient in the critical faculty and the sense of proportion so necessary to scientific campaigns. It was equally inevitable, perhaps fortunate, that such an invasion should be neither peaceful nor silent. There have been pitched battles between the immigrants and those who considered themselves to be in possession. There have been noisy and unseemly squabbles among the new inhabitants, and this turmoil has been going on in the midst of an international and social upheaval which has brought into relief, perhaps as never before, the strength and the weakness of the human mind, its success and its failure in adapting itself to strange and stressful circumstances. It is not to be wondered at that while the storm provided an immense amount of material for study, it created an atmosphere unsuited for well-considered judgments. The last year or two have, however, given us some leisure in which to review the origin, the progress, and the results of the new movement in psychology. I do not propose to enter upon a discussion of the merits or defects of our modern psychopathology and psychotherapy. In the first place, I shall summarize shortly our present position; in the second, I shall consider how to use what is best and most firmly established of our knowledge, old and new, of psychological processes for the advancement of mental hygiene. In fulfilling my first purpose I shall be dogmatic. My opinions will not be acceptable to everybody, although they probably represent more or less accurately the views of many psychiatrists and neurologists.

Value of Psychoanalysis

Psychoanalysis is essentially a method of scientific clinical investigation, and, like all other methods of scientific investigation, it requires in the investigator a trained and critical mind and in the investigated subject a degree of intelligence rather above than below the average, if the results obtained are to be of value. As Dr. Henry Head has repeatedly insisted, it is impossible to investigate the problems of sensation on subjects of low intelligence. The information obtained from such an investigation may be useful for purposes of

diagnosis and treatment, but should not be utilized for the construction of general principles.

Psychoanalysis is as necessary for the study of psychiatry as accurate and patient history taking is necessary for the elucidation of medical problems of organic origin. Psychoanalysis is not essentially a therapeutical measure. In certain cases it has a remedial value, either because it assists an intelligent patient to understand better, and therefore to deal better with, his mental disorder, or because it establishes a relationship of confidence between the doctor and the patient which is helpful to the latter and which is the fundamental requirement in all successful psychotherapy. Psychoanalysis as a method of investigation has been the means of establishing a number of truths and principles that are of great importance in the study of psychiatry. As Bernard Hart has recently stated, in terms that can hardly be improved upon:

"A great number of Freud's conceptions have withstood all the tests that can be applied to them, and it is not too much to say that they are now firmly incorporated in the structure of our knowledge. How far other sections of his teaching are sound cannot yet be decided with certainty, but they are at least worthy of careful scientific investigation free from the dust of conventional prejudice. It is certain that Freud's work has opened a new era in psychology and psychopathology, and his introduction of the dynamic point of view—the conception of mental processes as the resultant of the action and interaction of great instinctive forces—has fertilized immeasurably the arid field of the old academic psychology."

In claiming for Freud's work the opening of a new era in psychology, Dr. Hart has not gone one step too far, although he is careful to reserve judgment on the merits of many conceptions that have rapidly followed the inauguration of that era. Psychotherapy is a convenient name applicable to all forms of treatment that depend on education, persuasion, or suggestion, and not on physical or chemical influences, for their success. Although psychotherapy has been used by the medical profession for many generations, it has been recognized as a special method of treatment based on certain principles only within recent years. Its value in dealing with a

large number of mental disorders can hardly be overstated, and it is for the future to determine the limits of its usefulness.

Its Present Position

The present position of psychotherapy, as well as the diseases from which it suffers—if a remedy can be the subject of disease—were admirably described by Dr. T. A. Ross[1] in opening the discussion at the Cambridge meeting of the British Medical Association, and I cannot refrain from endorsing his eloquent plea for the establishment of a more friendly spirit among those who practice and put their faith in different methods. If this brief description of our present position in regard to psychopathology and psychotherapy is accepted, we are justified in hoping for a great advance in the practice of mental hygiene in the not very distant future. I would include under this term all measures that aim at the prevention of mental disorders, whether they are in the nature of neuroses, psychoneuroses, or psychoses.

Mental hygiene as a branch of medical science has been a miserable, neglected, and stunted plant, difficult to keep alive and still more difficult to rear, but it has a brighter future now that we are beginning to realize what it has lacked and to supply the necessary material for its development. It has always been the same in medicine. Hygiene in respect to tuberculosis was primitive and ignorant until the discovery of the tubercle bacillus. The prevention of sepsis was devoid of principles until the work of Pasteur and Lister paved the way. But if mental hygiene is to grow and to become robust, the soil must be prepared, a congenial atmosphere created, and sufficient labor and material provided.

Origin of "Nerves"

Let me turn your attention to some of the weeds that have choked the plant we would see flourish. To my mind the strongest and most obnoxious is one that was sown in ignorance and that has been nourished on fear. I refer to the fallacious belief, deeply implanted in the public mind and waiting a long-delayed exhumation by our profession, that so-called functional nervous disorders or "nerves" are not

1 See *British Medical Journal*, October 23, 1920, p. 619.

mental disorders. Surely the time has come to discard a verbal quibble that is unworthy of a scientific profession. There are signs in the air which lead me to think that unless we take this step ourselves the weed will be uprooted before our eyes by force of public opinion. But if we ourselves eradicate this weed, we shall, in the first place, be able to speak quite as frankly about mental disorders as about gastric disorders, and to discuss psychotherapy as freely as we do diet. If we recognize, and cause to be recognized, that there are all degrees and kinds of mental disorders, we shall gradually, but surely, break down the barrier that at present separates "nerves" from insanity, and that preserves for the latter the position of a mysterious and malign ogre lurking in the background and ready to pounce upon its victims from an unseen world. No harm is or ever can be done by dispelling ignorance or clearing up mystery. The fear of insanity, the fear of the unknown, the fear of something coming on them without provocation and finding them defenseless, haunts a multitude of patients and prevents that peace of mind which is the first essential in restoring their "nerves". Tell them that their symptoms are mental, that they have long suffered from a disorder of mind, and familiarity will breed contempt in place of unspoken fear. By so doing you will remove the feeling of defenselessness, and promote a confidence that the condition is understood and that your treatment is not based on a wrong diagnosis. It is useless to tell a patient who is obsessed by the fear of insanity that he is only suffering from "nerves". In nine cases out of ten, he will suspect either that you are deceiving him or that you are ignorant. Let him see that you recognize his symptoms as mental, and he will leave the treatment in your hands.

Needless to say, what I have here outlined is not sufficient. It is necessary to explain that what you mean by mental disorders are of everyday occurrence and in every one's experience. You will instance the fact that you may suffer from an obsession that is dispelled by a night's sleep or by talking to a sympathetic friend; that such an occurrence is not a question of nerves, but illustrates a transient disorder of mind. Moreover, you must explain that although symptoms are mental, they are not necessarily of mental origin. They may be due

to other, more physical, causes, or to a combination of both. For this reason it is necessary to make both a physical and a psychical examination, the latter perhaps including a careful investigation of the patient's past and present reactions to circumstances and environment. In these days you will hardly need to emphasize the fact that the condition of the teeth, of the lower bowel, or of the ductless glands may play a part, even if a subordinate one, in the production of mental disorder. It will take years before public opinion accepts the idea that mental disorders are among the commonest of ills and that we all suffer from them in a greater or less degree. But once insanity or madness is generally regarded only as an advanced form of mental disorder and not as an independent monster without relationship to other conditions, it will lose much of its frightfulness.

The theme I have entered upon could be pursued in many directions, but I can safely leave the trail to be followed by my audience. I am only concerned really with the plea that we should get rid of false terms such as "nervous" disorders when we mean "mental" disorders, and so clear the ground of the chief obstacle to rational mental hygiene. May I add that I am not preaching what I do not practice, and that I have seen no reason to regret the introduction of the word "mental" to patients when I have had the time to explain precisely what meaning I attach to it? In fact, it is a very necessary preliminary to the initiation of a course of psychotherapy.

Confusion of Ethical and Physiological Issues

My next weed must be treated with more tenderness and respect. It has intimate relations with our plant and would almost appear to grow on the same stem. Nevertheless, it needs pruning and checking in certain directions if the sap of scientific hygiene is to be preserved. As there is difficulty in distinguishing the leaves of a tree from the ivy creeping over its branches, so is there confusion in mental hygiene between physiological and ethical issues, or—as I am in the habit of putting it to patients—between medicine and morality. Ethical doctrines based on religion are, speaking generally and in view of their antiquity, surprisingly useful in mental

hygiene, but they need revision in certain particulars. The whole subject is too vast to admit of full discussion here, but I can make my meaning clear by an example which must be familiar to all of you.

A woman is beset by a fear or an anxiety or a sorrow—it does not matter which—but it is one that, according to her ethical upbringing, she must harbor in silence. She determines to suppress it and, again in accordance with her ethics, seeks success by throwing all her energies into some pursuit. Ignorant of physiological or psychological principles, she is surprised sooner or later to find herself beaten, and in the moment of defeat, when emotional reaction can no longer be restrained, she cries, "To think that I—I who always despised women with nerves—should come to this!"

Such a commonplace story illustrates two points of importance in relation to mental hygiene. In the first place, the patient has been brought up in ignorance of the fact that the mind, like the body, can be exhausted, and that an individual's endurance is a variable quantity determined by more than one factor. According to her ethical doctrine, the success of her enterprise depended merely on the strength of her will. In the second place, her piteous cry revealed the critical attitude of mind which, as a healthy person, she had always cherished toward those whom she had regarded as of inferior moral fiber. If her heart had become dilated as the result of prolonged and over-strenuous exercise, there would have been no self-reproach. She would have gone to bed and received the visits of her friends with complacence and without a suspicion of shame. There must be something wrong with the training of youth if a story such as this is of everyday occurrence, and mental hygiene will not flourish in an atmosphere containing so much ignorance of psychological principles and so little charitable discrimination between medical and moral factors.

Creation of Environment for Advancement of Mental Hygiene

So far I have been concerned with two measures that appear to be essential in creating a healthy environment for the growth of mental hygiene. They may be summarized in very few words. Disorders of mind should be generally recognized

as such, and the moral stigmata attaching to them should be dissipated. Such favorable conditions can be created only by the influence of the rank and file of the medical profession on the public. The time is ripe for a peaceful revolution of this kind. Both the profession and the public are more interested in psychological problems than ever before, and it requires only concerted and carefully considered action to direct this interest along healthy and beneficent lines. So far the increased interest in the mental side of our professional work has been reflected officially by the establishment of diplomas in psychological medicine, a step that should lead to valuable results by securing for this wide field of research a sufficiency of skilled labor.

But personally I do not want to see psychological medicine a special branch of a student's curriculum necessitating a three months' course in a special department. The student has more than enough to bear in the matter of special departments already. He need not be made familiar with all the writings, all the conceptions of Freud, Jung, or the older psychiatrists. He should learn from any or all of his medical teachers how to recognize, how to investigate, and the broad principles of treating cases of mental disorder. Patients suffering from minor mental maladies will form the bulk of his practice when he is qualified, and, since mental hygiene is concerned principally with the young, the general practitioner of the future must be responsible for its success. He cannot depute these responsibilities to a medical officer of health appointed by municipal authorities. He alone can detect which child in a family is finding difficulty in adaptation to the realities of life or to environment. He only can decide whether a threatening neurosis or an incipient regression is due more to inherent defects in the child or to external causes. His treatment will need to be directed as often to the parents as to their offspring if he is to be successful in preserving the mental health of the latter.

Five-and-twenty years ago a student was taught to distinguish between organic disease and functional disorder in his patients. The diagnosis of organic disease was followed by a discussion on the etiology and pathology of the condition, and the student was able to watch the effects of an elaborate

regimen of treatment to its appropriate or inappropriate termination. The diagnosis of a functional disorder, really a mental disorder, but not so called, evoked no comparable consequences. The page reserved for etiology and pathology remained blank, and the treatment was either purely physical or consisted of a few mild exhortations.

"You have no organic disease; you must not worry; you will recover in time; you must take plenty of exercise and have plenty of fresh air and good food."

This was generally accompanied by a good, strong strychnine-containing tonic, which possibly stimulated an already exhausted patient to further unguided efforts on entirely unsuitable lines.

Recent acquisitions to our knowledge of psychopathology should have sufficed to make the methods I have described so crudely unrecognizable to the student of the present day. Still more do they encourage the hope that the number of victims of mental disorder may be appreciably diminished if modern principles of psychical investigation and psychotherapy are incorporated in general medical knowledge and do not remain the monopoly of a few specialists. The trend of events in our science always follows much the same lines. As soon as much knowledge has been acquired in any particular branch, our thoughts are inevitably switched to the prevention rather than to the curative aspects of the problems involved. We are still seeking cures for cancer because we know so little about its causation. We are far more interested in the prevention than in the cure of sepsis. Our profession has of recent years become more and more interested in the recognition of early signs of disease, or, rather, the signs of disordered function that precede structural changes. It is not too much to say that psychiatry can now join in this general pursuit and so promote the growth of mental hygiene.

Multiple Factors in Mental Hygiene

It may seem a far cry from the nightmare of a child who has supped not wisely, but too well, to the hallucinations of an asylum patient, and to put these two mental disorders in the same category might seem to be a bit of extravagance worthy only of a fanatic. But this nightmare incident illustrates well

the tendency we all suffer from in greater or less degree to unify our pathogenesis. We like to think the nightmare was due to indigestion. It saves trouble, and the responsibility for preventing further nightmares may safely be left to the mother. There must, however, have been at least two other factors in the production of the nightmare. There was the inherent constitutional factor which caused that child to have a nightmare, although his brother, after consuming the same supper, slept undisturbed. There was the psychological content of the child's mind which determined the nature of the dream and the emotional disturbance associated with it. The most profound skeptic of modern psychology will not ask us to believe that the story of a dream is a bolt from the blue, or that it is more intimately related to the content of the dreamer's stomach than to that of his mind. The supper was undoubtedly important and may be allotted the chief share of guilt, but the other factors are not to be neglected if the study of mental hygiene in relation to children is to yield fruit. The asylum patient suffers from hallucinations. Shall we be content to say that he does so because he is mad? Or shall we look forward to the time when the reason for his suffering and the factor that determined the nature of his hallucinations are revealed to us? Looked at in this light, the problem of the nursery and that of the asylum are not so far separated.

The multiplicity of factors is a doctrine that, as teachers, we should keep constantly before the minds of our students. As practitioners our success depends on its observance whatever branch of medicine engages our interest. There can be no doubt that the study of epilepsy, for instance, has suffered much in the past from ignoring the psychological factor, although I should be very reluctant to subscribe to the view that the disease is purely psychopathic. Important as it is to bear in mind the doctrine of multiple factors in general medicine, it must never be forgotten in mental hygiene. We are too apt to say of a patient suffering from a psychosis: "What can you expect? Look at his family history." Granted that the inherent factor has been predominant, is it not possible that a far-seeing mental hygiene might have so dealt with other factors that a serious disorder could have been averted? It is impossible not to sympathize with those

who hold that psychotherapy plays only an unimportant part in the treatment of a full-grown psychosis, but this attitude is very different from believing that it cannot be useful as a preventive measure at a more embryonic stage. Endeavor to imagine the terror that must be constantly present in the minds of many sane persons who are members of a mentally unstable family. Is it difficult to realize what comfort they would derive from a belief that heritage is not the only factor to be reckoned with and that medical learning is capable of recognizing and assessing the other factors, so that the long-dreaded calamity may be avoided? I have a shrewd suspicion that the advice in such cases to avoid over-strain and to keep the body healthy does not quite meet all requirements. Are there not unavoidable difficulties to be faced in every one's life, and are we not already in a position to advise how they may best be dealt with?

Value of Rest and Thought

Before leaving the professional aspects of mental hygiene, and lest I should be accused of a marked bias in favor of modern psychotherapy in the prevention and treatment of mental disorders, let me say a word on the question of rest. There is no doubt in my mind that the invaders of our borderland have unduly minimized the importance of rest as a physiological essential in the prevention and cure of the psychoneuroses. Rest and sleep must, to the end of the chapter, be necessary in treating a condition of exhaustion, however the latter is produced. It is contended that with simple fatigue, uncomplicated by an anxiety state, sleep is undisturbed and refreshing. But it must be remembered that fatigue of itself may convert potential anxieties into active anxieties by reason of that loss of sense of perspective and of proportion by which it is almost invariably accompanied. In this way insomnia and disturbed sleep are brought about and a vicious circle established. This is a matter of everyday experience, and one that must not be lost sight of in any system of mental hygiene.

There is another aspect of mental hygiene on which I should like to touch, but which should perhaps be addressed to educational authorities rather than to yourselves. The chief func-

tion of the mind is thinking, and it is doubtful whether an organ can retain its maximal health if its function is not adequately exercised. But exercise must be guided and trained, especially in the young, if it is to attain its object. A game of cricket in which the participants are ignorant of the rules and uninspired by any keenness is worse, as an educational exercise, than no game at all. Is thinking a function that needs no practice, no training? Hughlings Jackson, whose contributions to psychopathology, in advance of his time like most of his work, have been revived and admirably presented to us by Dr. Maurice Nicoll in a recent article on regression,[1] was in the habit of exhorting his house physicians to set aside some portion of the day or night for thinking. He advised us to choose some question that had been raised in the course of the day, to allow our powers of association to assert themselves, and to jot down the resulting ideas in a notebook. In other words, he stimulated us to look at each question from many points of view, and to give it as many and as various attachments as possible. The value of forming such a habit can hardly be denied, and its more general adoption might prove to be a powerful preservative of mental health. This memory has been revived by references in recent literature to the beneficial results attributed to conversational reëducation. It is contended that this form of psychotherapy relieves a patient's mental suffering by introducing to him other aspects of a conflict which have hitherto escaped his notice. The same principle is concerned in the commonplace experience of talking our troubles over with a sympathetic friend who, without adding to our knowledge, reveals them in different lights. If this hypothesis can be supported, is it not to be inferred that the ability to look at difficulties from many points of view is an asset of some value in the maintenance of mental health? Is it not equally justifiable to assume that this ability must to a large extent be a matter of training in our earlier days?

My recollection of school days may not be reliable, but this principle, if my memory serves me right, did not govern our education. We had little time allowed for thinking, no instruc-

[1] *The Conception of Regression in Psychological Medicine.* *The Lancet*, Vol. 1 for 1918, p. 797, June 8, 1918.

tion in thinking, and no encouragement to cultivate the art for ourselves. There was an atmosphere of rigidity in regard to what might be controversial subjects in unfettered minds, and a thing either was or was not the right thing to do. I can well remember the surprise experienced on leaving school in relation to matters of conduct and to opinions about individuals. The atmosphere had changed and questions previously regarded as finally settled were found to be worthy of discussion. Individuals were no longer pigeonholed in this or that category; some with a wholly undesirable reputation had reluctantly to be conceded one or more good qualities. It may be that the somewhat narrow attitude of mind engendered by school life was adequately corrected by subsequent influences, but it is hard to believe there is no room for more systematized education in wide thinking at that period of life when the mind is most impressionable and most ready to form habits of permanent value. According to our newspapers, the education of the working-class children has again this narrow outlook with a socialistic bias, and is indifferent to other points of view. This being so, it should not cause surprise if they experience mental and other conflicts in later life. This is not altogether a frivolous utterance on my part. It can hardly be disputed that a large factor in present-day social unrest is of psychological origin, and that broader education on the lines I have just indicated would serve not only mental, but social hygiene.

Summary and Conclusion

There are other aspects of mental hygiene concerned with schools and education, especially in relation to hours of sleep and work, but these have received attention elsewhere, and I will not detain you with them now. Having trespassed on territory where I have no authority, I will be content with the inroad I have made and retrace my steps. To recapitulate, mental hygiene is a young plant worth cultivating and full of promise. Its growth must be promoted: (1) By no longer misnaming mental disorders as nervous. It is perhaps time to be courageous and to call institutions hospitals or clinics for minor mental disorders in preference to functional nervous disorders. (2) By getting rid of the confusion between ethical

and medical principles as they affect health. (3) By teaching elementary principles of psychopathology and psychotherapy to students in order that the general practitioner may take a prominent part in maintaining the mental health of individuals; these subjects, being more important than much that the student is called upon to know, should be introduced into the syllabus for examinations and questions set upon them. (4) By obtaining general recognition for the multiplicity of factors concerned in producing mental as well as other disorders. (5) By giving due prominence to fatigue as a factor in psychopathology and to rest in psychotherapy. (6) By encouraging education in thinking as an important preventive measure.

I am conscious that I have displayed my admiration for, and belief in, much of the newer psychotherapy, but I am not really unmindful of what has gone before. The present condition of psychiatry and of mental hygiene—immature as it is, but full of promise for the future—could not have been reached without the mass of invaluable research undertaken and carried out in the past by many great workers in this department of medicine. If a flood of light has been thrown on the results of their labors by a later generation, let us bear witness to the fact that it only adds a brighter luster to their names.

HABIT CLINICS FOR CHILDREN OF THE PRE-SCHOOL AGE*

DOUGLAS A. THOM, M.D.

Chief of the Out-patient Department, Boston Psychopathic Hospital

AT the request of the Baby Hygiene Association, of Boston, I was delegated early in November, 1921, to make a survey of one of their health clinics to determine whether a psychiatrist might have anything of value to contribute to their program of preventive medicine as it related to the care of children during the first five or six years of life.

I recall my doubts and misgivings when I was informed that the problem of studying the mental life of these immature youngsters would be complicated by having to deal with parents whose interest in abstract problems might be at low ebb, to say nothing of the barriers that might arise from language difficulties. I soon learned, however, that the problems were not abstract and that the language difficulties had been much exaggerated.

A visit to one of these clinics not only demonstrated the need of some one who was willing to study the child and his mental life, but stimulated a keen desire to begin at once. Consequently there was established what we please to term a habit clinic, the first of its kind to be held in Boston.

The assets of the new clinic were very modest indeed, including a psychiatrist one afternoon a week, a pad of paper and pencil, a chair and table in the nursery, and the necessary equipment for making a complete physical and neurological examination.

The function of the habit clinic is to deal with those children who are developing during the pre-school age—that is, between the ages of two and five years—undesirable methods of meeting the daily problems with which they are confronted, to further the formation of habits that will tend toward the proper development of the child and its best interests, to deter

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mine in so far as possible the basis of undesirable habits and unhealthy methods of reaction, and to institute proper training and treatment to overcome such habits. In brief, the habit clinic has for its objective the healthy development of the mental aspect of the child's life, beginning at a time when methods of prevention rather than of cure can be utilized.

We do not feel it necessary to seek justification for the organization of these clinics in some vague, ill-defined hope that they may tend toward the prevention of mental disease; we feel that their existence is justified by the immediate results obtained. A neurotic child or one struggling with some undesirable habit problem, who is finding it difficult to make early adaptations and to face everyday problems in a normal, healthy manner, may very easily become the dominant member of the household and not infrequently be the direct or indirect cause of much family strife. All too frequently such a child becomes the economic hazard or the social menace that eventually leads to the disintegration of the home. Such a child not only demands, but usually gets, a disproportionate share of the parents' time, to the neglect of the other children and their consequent jealousy, envy, and resentment. Although no claim is made at this time that there is any relation between these undesirable habits in childhood and the mental breakdowns of later life, it is not difficult to see that these infantile reactions closely resemble the psychoneurotic manifestations in adult life and that a fundamental lack of inhibitions may be the dominating characteristic in a criminal career.

We all appreciate that the success or failure of the individual to adapt himself in a manner satisfactory to those with whom he is associated may depend upon numerous and varied factors, all very intricate and involved and frequently closely interwoven with one another—bad bodily health dependent, perhaps, upon some simple problem of nutrition or an improper balance between the glands of internal secretion, a nervous system incapable of functioning in a normal manner, and the less well-defined inherent defects that prevent the normal development of the instinctive and emotional life of the individual.

Although one or more of the foregoing factors may be present in a great majority of the cases that are "failing to

make the grade", we cannot ignore the fact that often the stumblingblock is not within the individual himself, but in the environment in which he is reared—that there is a group of cases, how large or small we cannot say at this time, who become the victims of their environment rather than of their heredity, their economic or social failure having its origin in the mental conflicts of childhood and in the development of unhealthy methods of dealing with mental problems. It is obvious, therefore, that it will be greatly to the advantage of the particular individual concerned and of those with whom he is to come in contact in future years if such conflicts can be unearthed and such unhealthy methods of reaction corrected at the age of five instead of at thirty. Whatever view one may hold regarding the fundamentals of character and personality, we are, I think, all agreed that there are certain instincts, "innate tendencies", natural inclinations or propensities—call them what you will—which are lying dormant in the individual from birth ready to be called into service, usually at the necessary time and with the proper force to meet the best needs of the individual. The stimuli that actuate these forces may come either from within the individual or from the environment, and it is for the purpose of attempting to guide, to inhibit, or to stimulate these instinctive forces, which may be underdeveloped or overdeveloped or imperfectly developed, that we study the mental life of the child, utilizing behavior as the medium of interpretation.

It is not my purpose to enter into the psychology of habit formation, but simply to mention in passing a few of the fundamentals, necessary for the development of every human being, that are more in evidence during childhood than at any other period of life. Those that strike me as being of particular importance because of their utility are plasticity, suggestibility, imitativeness, and a love of approbation. These four characteristics, so dominant during the first few years of life, are invaluable assets in our efforts to model and remodel personality.

The home represents the workshop in which these personalities are being developed, and the mental atmosphere of the home can be very easily contaminated. The ever-changing moods of the parents, colored by their indifference, their quar-

rels, depressions, and resentments, and shown by their manner of speech and action, are decidedly unhealthy; so, too, are the timidity of a mother, the arrogance of a father, the self-consciousness of a younger sister, and the egotism of an older brother. Under such conditions we find a mental atmosphere as dangerous to the child as if it were contaminated by scarlet fever, diphtheria, or typhoid. On the other hand, cheerfulness, affection, kindly consideration, cleanliness, a manner and speech that are not forbidding but show interest in the questions of the child, frankness and honesty in answering questions with the idea of developing freedom in speech and action not inhibited by fear of punishment or silent contempt—all these things play a part in the development of the personality of the child that cannot be overestimated. The environment is found to be mirrored in the character of the child, regardless of what his heredity may be.

I have already stated that the problems were not as abstract as I had anticipated. Take, for example, the case of two youngsters in the same family, one just over five, the other over six years of age. The younger, Gertrude, was brought to the clinic on account of persistent bed wetting and walking in her sleep. She would wake up frightened and cry out, disturbing the entire household. The older, Helen, also a persistent bed wetter, for the past three weeks had been vomiting every morning and occasionally during the day, and was very untidy in her dress and general habits. Both children were a great problem to the mother. She stated that it seemed as if she did nothing but wash sheets all day long, and since Helen had begun vomiting, her daily routine had become even more difficult. The conditions in the home were described by a psychiatric social worker as follows: The family lived in three miserable rooms with low ceilings, small windows, and floors in a bad condition, showing that apparently no attempt had been made to do any cleaning for several days. Piles of soiled clothing were lying around, and wood and coal were scattered about the stove. In one of the rooms there was a small open toilet for the children to which they went frequently and which the woman emptied at infrequent intervals. A towel and wash cloth that hung by the sink and that were used to wash the baby's face were indescribably dirty. The air in the room was very bad.

The mother, a woman of no particular intelligence who was able to speak only rather broken English, was five months pregnant. She stated that she often wondered what she had to live for. She seemed to be afraid of her children, but on the other hand was very fearful that some harm might come to them. She walked to school with them twice every day because she was afraid that the bigger children would knock them down. There were four children, the two of whom I have been speaking, Helen and Gertrude, being the oldest. It was not difficult to determine that Helen's vomiting was purely a matter of imitation. The mother had been vomiting herself (because of her pregnancy) for the past months, often in the presence of the child. The bed wetting of both children had been tolerated and no attempt had been made to establish a routine that would tend to break up this habit.

Within two weeks the vomiting and the bed wetting of both children were stopped by very simple, common-sense measures. I need not say that the mother was much gratified at getting results by following our simple instructions. An effort is now being made to help her with the family budget—as the income of the father is sufficient to provide much more comfort than the family are getting—and to teach her some of the principles of cleanliness and household efficiency. In this case our success with the children was the initial wedge in getting into the household and doing something for the entire family.

Another little girl, aged three and one-half years, was brought to the clinic because of terrifying dreams, an intense fear of dogs, and extreme shyness. It was only after the third visit to the clinic that the mother herself threw much light on the origin of the child's fear of dogs. She stated that when she was about eighteen years of age, she herself had had a rather terrifying experience in being chased by a dog and this fear had persisted for a long time. Remembering her own fear of dogs, she had felt that it would not be a bad plan to instill this same fear in her child, and for months past she had frightened the little girl, when she was disobedient, by threatening to go and get the dog, and when out on the street with the child, she always pretended to be afraid when dogs were present, although she had actually overcome her own fear. By instructing the mother and giving the child a proper attitude toward animals, this fear was soon banished.

and the terrifying dreams ceased without any further treatment. The child is still very shy, but is making contacts with other children, and the prognosis seems good.

Another little girl, Frances, aged two, was brought to the clinic by her mother because she was making vicious attacks upon her little sister Ruth, aged four. The day before her visit to the clinic, she had bitten her sister on the abdomen and scratched her face rather severely. Investigation of this particular situation revealed the fact that the father had noticed, when Frances was but eighteen months old, that she showed rather unusual and amusing reactions whenever he petted her older sister. It soon became his pastime, when he came home from work, to make a great deal of Ruth in order to arouse antagonism in Frances. He did not realize the danger of this particular form of amusement. Here we have a good example of jealousy being developed in pure culture, an emotional reaction that we are all quite aware not infrequently leads to serious difficulties.

Another youngster, aged five and one-half years, refused food unless fed by her aunt. When left alone with the food, she hid it and then told fanciful tales of what had happened to it. A careful examination at the Children's Hospital, in order to determine whether the refusal of food had any organic basis, gave negative results, and measures were then instituted that ended in the child's being willing to feed herself, thus relieving the family of an unusually wearisome task.

Paul, aged four, an alert lad of normal intelligence, every now and then caused much concern in the family by losing his voice. The reason for the trouble was quite obscure until Mrs. N. reported at the out-patient clinic at the Psychopathic Hospital with the identical complaint. Investigation revealed the fact that Paul lived in the same house with Mrs. N. and that he spent as much time in her home as he did in his own. This symptom, like that of persistent vomiting just described, was one that had its basis in the imitative tendency so well marked in children.

The following case, although nine years of age and not in the pre-school group, is mentioned in closing to illustrate the development of symptoms that begin in very early life.

The little girl in question was brought to the clinic because

of sex delinquencies and the lack of a sense of shame. The father is said to be a very sane, sensible sort of man who is making every effort to care for his family. The mother was an epileptic with hypersexual tendencies, who died at the Psychopathic Hospital about four years ago from a toxic psychosis. The father married again, and although the stepmother is trying hard to cope with the present family situation, she has not been particularly successful on account of the older stepdaughters. At the present time she is separated from her husband because of the conduct of the patient and the lack of support she got from other members of the family in her efforts to make things go right. For the past three years, or since the age of six, the patient has been known to have been having sex relations with various boys in the vicinity; on several occasions she has been found in the cellar of an unoccupied house near her home absolutely nude, with three or four boys of about her own age. She tells her father in detail what has happened and shows no sense of shame whatever in speaking of the active part that she has played in these episodes. Her father states that she has shown abnormal interest in sexual things for the past three years at least. After coming home from the moving pictures, she seems to remember nothing but the sexual aspect of the picture, frequently fabricating and interweaving sensual situations that have no foundation in fact.

In the psychological examination, this little girl graded a year beyond her actual age. In the examining room she answered all questions quite openly and frankly. She evidenced an extremely precocious interest and a very intimate knowledge of sex affairs, which could have been gained only by personal experience. She made no effort to minimize her part in these unfortunate episodes, but did express quite voluntarily a desire to overcome her hypersexual tendencies. She realized that her delinquencies were breaking up the home and showed fondness for her stepmother and appreciation of the fact that she was trying to be of help. This patient has been seen on four different occasions, and we have every reason to believe that much will be accomplished towards solving her difficulties through reëducation and a change of environment.

I feel that it is extremely important that such a clinic as I

have described be very closely associated with some general health movement, first because of the advantage thus gained in being able to refer the patient from one specialist to another as occasion demands, and second because of the opportunity afforded to present psychiatry in a very practical way to the medical profession at large.

I have not lost sight of the fact that many of the foregoing conditions described as "undesirable habits" might well be considered self-eliminating, yet this in no way justifies us in ignoring them. It is important to appreciate the fact that the child reacts on a much lower level than the adult and that there is a marked difference between the purely instinctive reactions of children of the pre-school age and the more elaborate personality reactions in adult life. I believe that the reactions of childhood can be interpreted more accurately and with less difficulty than those of adult life.

The importance of establishing habit clinics in the communities where these children live and in the nurseries with which they are familiar is well worthy of consideration. Such location serves two distinct purposes: first, it renders the clinic available to many children whose parents would find it quite impossible to seek advice from the hospital, and second, it permits us to observe the child under more normal conditions than we would find in the ordinary out-patient clinic.

A great deal may be expected from developing psychiatric social workers in this field. Undoubtedly we shall find that, when properly trained, they are capable of assuming far greater responsibilities than we have heretofore been inclined to put upon them.

Up to the present time we have done no more than establish the fact that there are many intricate and involved problems relating to children of the pre-school age in which the psychiatrist and psychologist and psychiatric social worker can render most valuable service. The task at hand is to develop, in so far as possible, definite means and methods of dealing with these problems, getting away from vague generalities as much as the analysis of our material justifies.

THE INAUGURATION OF A STATE-WIDE PUBLIC-SCHOOL MENTAL CLINIC IN MASSACHUSETTS*

WALTER E. FERNALD, M.D.

Superintendent, Massachusetts School for the Feebleminded

THE Massachusetts legislature enacted the following law in 1919:

An Act to Determine the Number of Children Retarded in Mental Development and to Provide for Their Instruction

Section I. The school committee of each city and town shall, within one year after the passage of this act, and annually thereafter, ascertain, under regulations prescribed by the board of education and the director of the commission on mental diseases, the number of children three years or more retarded in mental development who are in attendance upon the public schools of its city or town, or who are of school age, and reside therein.

Section II. At the beginning of the school year of nineteen hundred and twenty, the school committee of each city and town in which there are ten or more children three years or more retarded shall establish special classes to give such children instruction adapted to their mental attainments, under regulations prescribed by the board of education.

General Acts, Chapter 277, approved July 1, 1919.

In accordance with the provisions of this act, the department of education and the commissioner of the department of mental diseases have formulated regulations and instructions for applying the provisions of the act throughout the entire state.

It was decided that this work should be done under the direction of skilled psychiatrists. One physician was selected from each of the state hospitals and from each of the schools for the feebleminded for this purpose, twelve in all. These physicians were given a course of intensive training, dealing with feeblemindedness in all its phases, its varieties, degrees, causes, diagnosis, treatment and training, and the like. The examination and diagnosis of individual cases constituted a very important part of this course. It was strongly stressed that the usefulness of the clinics would depend very largely upon

* Read at the Forty-sixth Annual Meeting of the American Association for the Study of the Feebleminded, St. Louis, May 20, 1922.

the tact and sympathy of the examiners towards the pupil, his parents, the school authorities, etc. It is a very serious matter even to suspect a child of being mentally deficient. A mistake in diagnosis would be a tragedy. In case of doubt, the diagnosis should always be deferred for further examination or until the evidence is conclusive.

The entire state was divided into twelve districts, each district roughly corresponding to the area served by one of the state hospitals or one of the schools for the feebleminded. The specially trained psychiatrist from each institution is responsible for the examination of the retarded pupils in that district. In this way provision is made for the examination of every retarded pupil in the state—for the one backward child in the remote mountain district as well as for the children in the thickly settled city. The psychiatrist from each of the state hospitals devotes several days a week to this work. Each of the two schools for the feebleminded has a traveling clinic, consisting of a psychiatrist, a psychologist, a social worker, and a clerk, who devote their entire time to the work. On account of this full-time staff, the schools for the feebleminded have assigned to their territories some of the rather widely scattered industrial centers of the state. It is expected that each community will be visited by the examiners at least once each year, and as many as possible of the retarded children in that community examined. This plan will ultimately provide for the examination of all the retarded pupils in each community. It is a simple matter for officials selected by the state to go into a city or town and decide upon the mentality of the school pupils; but it would be a very difficult matter for the local school authorities to do this without arousing antagonism.

These clinics were begun in March, 1921. Approximately 4,500 cases have been examined and reported up to May 1, 1922. The work is well under way in the cities and large towns, but many small towns have not yet been reached. Without exception, the local school authorities have willingly and intelligently coöperated in this work. In no city or town has there been any real difficulty.

The clinic examiners have nothing to do with the selection of the pupils to be examined. They are selected by the local

school authorities. The different cities and towns have various methods of selecting these pupils. The majority are actually selected because, in the judgment of the teacher or of the principal, they are definitely retarded. They are usually found in school grades two or three or more years above the grades whose work they are able to do. In several cities modifications of various group-intelligence tests have been used for the primary selection of pupils for individual examination. In addition to the children who have repeated grades or who have been assigned to grades beyond their capacity, a group is presented of children just entering school who are obviously not able to begin first- or second-grade work, and who, in the judgment of the teachers, are definitely retarded. Apparently the sensibilities of no parents have been wounded by the examinations and the reports of the results.

Some of the cities have selected only the children eight, nine, and ten years of age; others have selected children with ages ranging from six to sixteen years; still others have selected only those from eleven to sixteen years. In 1,000 consecutive cases examined by the clinic, the chronological ages have been as follows:

Age	*Number*
6 years	7
7 years	40
8 years	65
9 years	90
10 years	105
11 years	120
12 years	130
13 years	191
14 years	145
15 years	94
16 years	13

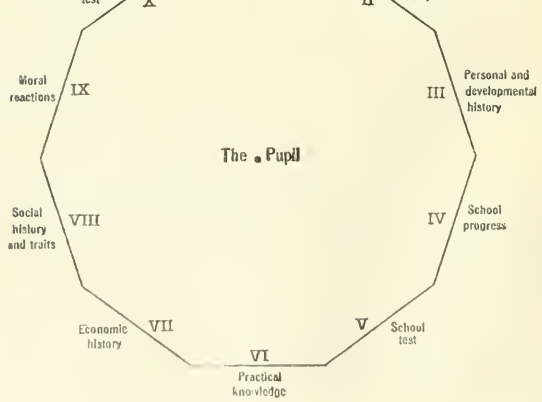
It was decided that all children should be examined by the same method, and that the examination should include the following fields of inquiry:

1. Physical examination
2. Family history
3. Personal and developmental history
4. History of school progress
5. Examination in school work
6. Practical knowledge and general information

7. Economic efficiency
8. Social history and traits
9. Moral reactions
10. Psychological examination

A special syllabus for each field of inquiry has been developed, each on a separate sheet.

Full information from each of the above fields is necessary in order to make a consistent diagnosis and as a basis for the future treatment and training of the pupil, for we have found that worth-while advice must be based upon the most complete knowledge and understanding of the patient—his bodily constitution and make-up, heredity, environment, clinical and developmental history, school record, pedagogical measurements, capacity for family and social adaptation, the presence or absence in him of innate or acquired character or personality complexes, and his response to a thorough psychometric examination. This information constitutes a cross section of the child himself—an evaluation, as it were, of his possibilities and limitations, so far as they are ascertainable. The thoroughness of this form of inquiry is well expressed by the following diagram:



The traveling clinic visits the cities in turn, usually spending a week in each. The group is able to examine from fifty to sixty pupils in a five-day week, depending upon the chronological ages and the mental ages of the pupils examined. The examination really consists of a series of examinations, and the work is divided as follows:

The social worker goes to the city six weeks before the visit of the clinical group, and arranges with the superintendent of schools for the time of the proposed visit of the clinic, the number of children to be examined, the location of these pupils as to school buildings, and the like, and plans with him for the selection of a teacher competent to give the school tests. If necessary, this teacher receives special instruction as to giving the school tests and the scoring of the same.

The school nurse or other socially minded member of the school organization is instructed as to the technique of taking the histories. She visits the family and obtains the mother's consent to the examination. She secures the family, personal and developmental, economic, social, and moral history of the pupil. The history of school progress, showing the age upon entering school, etc., is furnished by the school teacher or by the school nurse. These histories should be completed, written up, and available before the traveling clinic actually visits the city.

In some of the cities all the children to be examined from the entire city are brought to some central point, usually school headquarters. In other cities, they are examined in groups in school buildings in various parts of the city, the pupils being brought in from the distant schools. Two rooms are usually necessary for this purpose, one for the psychologist, which should be as quiet and free from interruptions as possible, and another for the psychiatrist, equipped with scales for weight and measure. It is necessary to have a school nurse or a teacher assigned to present the children to the examiners in turn.

The psychiatrist makes the physical examinations and measurements, obtains the clinical and developmental history, and gets the data as to practical knowledge and general information.

The psychologist makes a thorough psychological examination.

The records of the examinations and findings in each of these ten fields of inquiry are now available for the psychiatrist to make the diagnosis and to formulate the advice and recommendations for each individual pupil.

The diagnostic significance of the findings in the ten fields of inquiry have been described in previous papers by the writer.[1]

It cannot be too strongly emphasized that the mental diagnosis throws light on only one part of the problem of the individual pupil. The other information obtained is necessary if we are to accomplish much for his betterment.

These clinics have been made constructive from the start, the purpose of the examination being not to discredit the backward child in any way, but rather to find his present capacity for training, his probable rate of progress, his personal handicaps or special abilities, and the like. In other words, this examination catalogues his possibilities as well as his limitations, and has for its main purpose the idea of improving the child's condition as much as possible. The detailed information which can always be obtained in some of the fields of inquiry renders it possible to make a thorough diagnosis of the condition of the pupil and furnishes the basis for the specific advice that is given for each case examined.

The advice given is based upon the facts revealed in the ten fields of inquiry as to the pupil's physical condition, home conditions, personal history, school progress, social and moral reactions, as shown in school and elsewhere, and upon the results of the psychometric tests compared with definite pedagogical examinations—the actual school examinations in reading, arithmetic, etc. In other words, we compare what a child can do now in school with his school history as given by the teachers and as modified by his physical condition, home conditions, personality traits, mental age, etc.

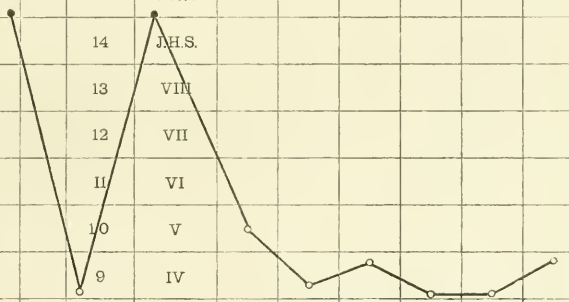
No two of these pupils are exactly alike. Their needs are different in almost every case. For instance, a girl of

[1] See *Standardized Fields of Inquiry for Clinical Studies of Border-line Defectives.* MENTAL HYGIENE, Vol. 3, pp. 566-74, October, 1919. See also *The Diagnosis of the Higher Grades of Mental Defect.* *American Journal of Insanity*, Vol. 70, pp. 253-64, January, 1914.

CORRELATION OF CHRONOLOGICAL, MENTAL, AND SCHOOL AGE.

NAME DATE

Chronological age	I. Q.	Mental age	School grade for present chronological age	Reading	Arithmetic	Spelling	Writing	Geography	Language
16	.63	16	H.S.II						
15		15	H.S.I						
14		14	J.H.S.						
13		13	VIII						
12		12	VII						
11		11	VI						
10		10	V						
9		9	IV						
8		8	III						
7		7	II						
6		6	I						
5		5							
4		4							
3		3							
2		2							
1		1							



thirteen, with a robust body, able to do second-grade work only—a mental age of seven—with keen sex interests, a poor home, and a mentally deficient mother, would present certain problems vastly different from those presented by a girl of thirteen, moderately hydrocephalic, markedly underweight and badly nourished, able to do third-grade work—a mental age of eight—with an obedient and conscientious make-up, no immoral tendencies, and a good home. Again a boy of fourteen, with a mental age of six, unable to do any school work, with a positive Wassermann, parents dead, and no home, would present an entirely different problem from that of a boy of twelve, with a mental age of eight, a comfortable home, intelligent parents, and no immoral or troublesome traits.

A formal report for each pupil examined is made to the local superintendent of schools. This report shows the child's chronological age, mental age, intelligence quotient, and number of years of retardation. In these reports—indeed, in the entire work of the clinic—the terms "feebleminded", "mentally deficient", and other opprobrious words are never used. A graphic chart, an example of which is given on page 477, showing the correlation of chronological age, mental age, and school age, is also furnished to the local school authorities for each pupil examined, with the advice that this chart be passed on from one teacher to another as the pupil is transferred from one room or grade to another.

The boy described by the chart on page 477 is fifteen years old. If he were normal, he would have a fifteen-year-mind and his intelligence quotient would be 100. A fifteen-year-mind generally means the capacity for doing first-year work in high school. The mental age of the boy shown on the chart, however, is on the nine-year level, and at this mental age he should be capable of doing fourth-grade school work. The application of the "school tests" shows that he is able to do fifth-grade reading and fourth-grade work in writing, arithmetic, spelling, etc. In other words, he is doing all that he is capable of doing.

The correlation chart is based upon the principle that the possibilities of school training at the different mental ages are quite definitely fixed as follows:

A child with a mental age of six years can usually do first-grade work
A child with a mental age of seven years can usually do second-grade work
A child with a mental age of eight years can usually do third-grade work
A child with a mental age of nine years can usually do fourth-grade work
A child with a mental age of ten or eleven years can usually do fifth-grade work (except perhaps in arithmetic)

Thus, when we have learned the mental age of a child, we can easily determine the grade of school work that he ought to be able to accomplish. In other words, the mental age tells what the child is able to do at a given time. A pupil is rarely able to do school work in even one grade above that corresponding to his mental age.

The mentality of 1,000 pupils examined consecutively by the clinic is given in the following summary:

Mental age	*Number*
2 years	4
3 years	13
4 years	27
5 years	66
6 years	150
7 years	193
8 years	272
9 years	173
10 years	66
11 years	20
12 years	10
13 years	4
14 years	2

The intelligence quotient shown on the correlation chart fairly predicts the mental age and school grade that the child will probably be able to reach at the age of sixteen years, the probable limit of his scholastic development. The following table shows the probable results to be expected with the different intelligence quotients:

Intelligence quotient	*Probable adult mental age*	*Probable final school grade*
30	5	Kindergarten
40	6	First grade
45	7	Second grade
50	8	Second or third grade
60	9	Third or fourth grade
65	10	Fourth or fifth grade
70	11 or 12	Fifth or sixth grade (except perhaps in arithmetic)

To sum up, the correlation chart shows the school-grade level that a pupil is theoretically able to reach at the present

time with a given mental age, the actual school performance as shown by the "school tests", and the probable sixteen-year limit of scholastic work, as shown by the intelligence quotient.

In addition to the definite facts given above, explicit constructive advice is given for each pupil. The specific advice can be classified into several main groups, as follows:

I. "*Continue in grade.*"

We usually advise this for a child who is more than twelve years of age, where the mental defect is not too obvious. At this age the child is too old to be put in the special class without feeling that he is ignominiously demoted. When special classes are provided for older children with only moderate defect, this objection will be removed.

II. "*Needs special class.*"

We have generally given this advice for all children under twelve years of age who are three or more years retarded. We also advise placing in the special classes children over twelve years of age who are physically unfit or who are markedly defective.

III. "*Needs manual and industrial training.*"

Experience shows that backward children who succeed in life do so because they become capable of doing worth-while work with their hands. This is really the end and aim of all training with such pupils. This kind of training begins, according to the age of the child and his mental age, with the use of pencils, rulers, crayons, water colors, paper folding, paper cutting, etc., and has for its ultimate aim actual work with tools and materials, such as carpentry work, painting, weaving, cobbling, etc. It is important that this training should be intensively carried on from the age of twelve until the child leaves school. Special classes often weary the children by long-continued use of kindergarten work, with raffia, beads, etc., for the mere making of pretty, useless designs, which to the child have little connection with the realities of life. Work of this sort, which is alright for a little child, becomes absurd for the boy or girl of twelve, or

thirteen, or fourteen years of age. For the single special class, we can visualize a room with a rough bench covered with paint pots and brushes, wood saws and other tools, with a loom, a shoemaker's bench, a sewing machine, etc. It would be a great thing to have a pile of bricks, a wheelbarrow, a chance to use a pick and shovel, etc.

The trade classes and vocational classes usually require a child to be able to do sixth-grade work before he can enter them. Feebleminded boys and girls with a mental age of nine or ten, and an intelligence quotient of from 60 to 70, who will never get beyond the third or fourth or fifth school-grade level, are deprived of the opportunities that should be furnished them in the trade or vocational schools. A moderate-sized city could well afford to have a workshop school, fitted up with lathes, looms, anvils, tools, and other appropriate working equipment for the proper training of these backward boys. We have not found it practicable to teach definite trades, but have found that as the boys soon tire of one occupation, their interest can be maintained by giving them training in the rudiments of wood work, metal work, textile work, etc. In fact, the simplest form of manual labor has a distinct educational value—the piling of bricks, the use of a wheelbarrow, etc. The main thing is to teach them how to work and to love to work.

Our experience shows that most boys of this mental age without character defects can almost always go out and get jobs at some manual work and earn their living at good wages.[1] We have to-day 160 boys who have gone out within a few years who earned during the year 1921 $130,000 in wages. We believe that this is largely because of the industrial training received during their formative years.

We cannot too strongly emphasize the need of having this workshop school conducted on a practical shop basis, with no "standards of perfection" as the aim. This

[1] See *After-Care Study of the Patients Discharged from Waverley for a Period of Twenty-five Years.* By Walter E. Fernald. *Ungraded,* Vol. 5, pp. 25-31, November, 1919. See also *One Hundred Institutionally Trained Male Defectives in the Community under Supervision.* By Mabel A. Matthews. MENTAL HYGIENE, Vol. 6, pp. 332-42, April, 1922.

shop will not at all correspond to the ideal of the technically trained teacher. These boys do nothing with elaborate measurements, working to scale, or carrying out other exact work. "The best the boy can do" should be good enough.

We believe this training should be part of the daily routine of these children from the age of twelve until they leave school. After the age of fourteen, we believe that this training should constitute the great bulk of their schooling, and that if this is done, the majority of boys with nine- or ten- or eleven-year mentalities who leave these classes should be able to go directly into industry and obtain good wages. The special training in these workshop classes should be varied according to the leading industries in the various cities. In the shoe city the handling of leather and the various work processes making up the shoe industry should be taught in detail. In the textile city the spinning of yarns, the handling and weaving of yarns into cloth, the handling of cloth, etc., should be specifically taught. We know that the pupils of Waverley who have done this sort of thing go back to these cities and get jobs without difficulty.

For the girls, the industrial and vocational training is just as important, but the work to be done should follow feminine interests. Domestic science, with a full equipment of appliances and the best trained teachers, should be the basis of this work. This domestic science should begin with the simplest details of housework—the sweeping of floors, dusting, washing dishes, blacking stoves, building fires, paring potatoes, making tea, setting a table, washing and ironing clothes, making beds, etc. The equipment for teaching should not be the elaborate equipment of a college class room, but should closely approximate the conditions in the domestic life of the ordinary family. All the feminine handicrafts should be included, such as knitting, crocheting, darning, embroidery, millinery, dressmaking, weaving, machine sewing, machine knitting, etc. This training, emphasized at the age of twelve and kept up daily until the girl leaves

school, making this vocational training most of the school training after the age of fourteen, would do much towards making these girls self-supporting and self-guiding.

Every city of any size has enough boys and girls who cannot go beyond the fourth or fifth grade, and who receive nothing from school work after eleven and twelve years of age, to make a splendid, large, successful school of this sort. We shall never do our duty towards these backward children until we supply them with the sort of training that will be useful to them later in life. The parents of these children are always appreciative and grateful for this training. The expense need not be large. Simply planned quarters like a business loft would be best for the purpose. Neither is the equipment needed expensive. One instructor could handle thirty or forty pupils at one time in this workshop school, and could carry on one class in the forenoon and one in the afternoon.

The value of the training is immensely greater if the work of the children is applied to something that is needed—to the making of articles that are to be sold or used by some one. The mentally defective child has little imagination and is not stimulated by making something merely to look at.

The above provision will ultimately be made in all of our cities. Until such provision is ready for children under the age of twelve, this manual training will have to be done in the special classes; for those defective children who continue in the grades, it will have to be done in the regular manual-training classes. Anything less than one hour a day for manual training is of little account. The instructors should fully understand the mental-age limitations and possibilities of each child. The work should be simplified until it is within the comprehension of the children who are being taught. This means that it must be much simpler than the work now being undertaken in these classes. Here again "the best the child can do is good enough".

IV. "Needs social supervision and protection."

This applies to nearly every child three or more years retarded. The sum of all the experience of the school authorities should be applied to the home and community life of the child, as well as to his school life until the age of sixteen, when he passes out of the control of the school authorities. The parents need to be informed as to the limitations and possibilities of their backward child, to be warned of his suggestibility, and of the great need for supervising his associates and habits during his formative period. The teacher of the school class can often utterly transform the life of a misunderstood child of this sort by explaining him to his parents and by pointing out where he needs special help and consideration. In certain homes, the parents should be instructed as to the sort of physical care that the child needs. The defective boy over fourteen needs a great deal of supervision out of school to prevent him from joining the wrong "gang" and to protect him from forming wrong habits. The parents of every backward girl should be urged repeatedly to protect the child from sex dangers and sex experiences. In talking with parents of the sex dangers to which defective girls are liable, it should be emphasized that the girl herself is not necessarily a moral menace, but that she should be protected from her lack of knowledge and intelligence and from having advantage taken of her. She needs more protection than the ordinary girl, especially at the period of puberty. We regard the opportunity for social supervision, interpreted in a wide sense, as one of the most important results of the school clinic. As a rule, the parents and the family are quite unaware of the child's limitations and of the special consideration and help that he will need until he is past adolescence. Much of this work can be accomplished by the school nurse or the attendance officer or other school officials, and especially by the child's teacher. We have found that such persons are often able to enlist the interest and assistance of the church or of altruistic men or women who are only too glad to show a long-continued interest in a problem of this sort.

V. "The child may become delinquent."

We are struck by the small, but persistent group of cases, found in all the cities, in which the child is reported as "quarrelsome", "stubborn", "passionate", "disobedient", "resentful of authority", and as lying and stealing. Several of the above traits, added to mental deficiency, mean that unless this pupil is most wisely understood and cared for, he will become delinquent at an early age. It is much easier to prevent delinquency than it is to cure it. Children who show the above characteristics should receive special social supervision and protection and assistance. The school authorities have the opportunity to confer with the welfare agencies, etc. It is probable that a large number of potential delinquents can be early recognized in the schools and adequately treated at the only time when future criminality can be prevented.

VI. "Needs medical attention."

The physical examination given each child naturally reveals many minor disabilities and conditions which should be referred to the proper clinics or to the proper physician.

We have merely indicated above the general scope of the specific advice given in individual cases. There is an infinite variety of advice given, such as: "Has probably reached his limit in scholastic work", "Intelligence not high enough for special class", "With this intelligence should be capable of doing (second or third or fourth) grade work", "Should get a paying job as soon as possible", and the like.

In accordance with the law, for each pupil found to be "three years or more retarded" a special report is made to the state department of mental diseases on a card giving the principal facts in the ten fields of inquiry, thus adding to the official census of the feebleminded in Massachusetts which is maintained by the department. In a few years this census will contain definite data as to practically all the feebleminded in the state, and will be the basis for an intelligent working out of a consistent program for the assistance, control, and supervision of the feebleminded of Massachusetts. This program may be summarized as follows:

"All of our experience with the feebleminded indicates that if we are to manage adequately the individual defective, we must recognize his condition while he is a child and protect him from evil influences, train and educate him according to his capacity, make him industrially efficient, teach him to acquire correct habits of living, and when he has reached adult life, continue to give him the friendly help and guidance he needs. If conditions are right, he may live at home and receive his training in the rural school or in the special class. If he is actually a social menace, he will need the institution. These advantages should be accessible to every feebleminded person in the state and not to a few favored persons. The rights of the feebleminded person and of his family should be guarded jealously, as well as the rights of society."

PERSONALITY IN THE MENTAL DEFECTIVE, WITH A METHOD FOR ITS EVALUATION*

HOWARD W. POTTER, M.D.
Clinical Director, Letchworth Village, Thiells, New York

THAT man has attained his present level of civilization and is able to live and work among his fellow men with the least degree of friction and the greatest amount of coöperation means that he not only possesses certain capabilities or assets of an intellectual value, but that, in addition, he has developed a facility in adjusting his behavior and reactions, which enables him to take his place as a cog in the machinery of industrial and social life and thus qualify for the credit rather than the debit column of the balance sheet of human efficiency.

Human efficiency depends upon the adjustment to three groups of factors—namely, in the order of their importance, instincts, emotions, and intelligence. It is not my intention to speak disparagingly of the value of intelligence, but it is my aim to indicate the significance of instinctive and emotional factors. Such primitive strivings and forces as these are certainly factors to be reckoned with, and it is their presence that necessitates adjustments. On the other hand, it is the incentive furnished by such fundamental dynamics that makes life what it is. Energy, ambition, competition, altruism, love, friendship, longings, cravings, hope, and so on are a part of instinct and emotion. They constitute the springs of human endeavor and behavior. Whether the endeavor and behavior are good, bad, or indifferent depends on the types of adjustment to these fundamentals.

This world would be in a chaotic state if we all followed the

* Read at the Forty-sixth Annual Session of the American Association for the Study of the Feebleminded, St. Louis, May 18-20, 1922.

dictates of our instincts and emotions. Yet all of us are born with them and show them in no uncertain manner in the various stages of our individual evolution. How are adjustments brought about? By precept and example, by trial and error, by punishment and reward, by training and self-discipline, do we develop a train of useful or faulty adjustments. How much part heredity plays in the various types of adjustment is an unsettled question, but personally I am willing to believe that these adjustments are more a matter of parental example and environmental influences than of parental chromosomes and inherited characteristics.

Behavior consists of action and reaction. Action and reaction depend on instincts, emotions or feelings, and purely intellectual forces. It is within the scope of this paper to consider how behavior may be modified by instinct and emotion. The mechanism by which action or reaction takes place may be termed an adjustment. The action or reaction may make for successful or unsuccessful social adaptation, depending upon whether the adjustment is such that it falls within or without certain social limitations or standards.

Action and reaction may be initiated at a conscious level, but if they be persisted in, in certain set ways, they attain an automatic value, are established as habits, and then take place subconsciously. We may therefore refer to successful or unsuccessful adaptations as the results of correct or faulty habits of adjustment.

When we come to consider the question of adaptation relative to the mental defective, we are at once impressed with the fact that those cases that are not committed to an institution until they approach maturity almost invariably are discovered to be feebleminded as the result of an investigation into some behavior disorder. We know further that there are other defectives, of the same intellectual level, who are at large in the community and able to fill a useful niche in the social and economic organization. Why is one in need of institutional care, while the other is able to live satisfactorily in the community? Plainly it is not a matter of intellectual endowment. It is, however, a matter of behavior. To understand behavior, we have to consider, among other things, the personality.

The personality represents the sum of the facilities for adaptation. A study of the personality will disclose what assets and liabilities the individual possesses. It reveals with what kinds of adjustment he meets his fundamental yearnings, strivings, and feelings. To be complete, a personality study must not only be an academic enumeration of various traits, but, in order to furnish a constructive basis, it must be interpreted in terms of reaction to underlying and fundamental emotional and instinctive forces.

My aim in advocating personality studies of mental defectives is manifold:

1. Such a study places the intellectual level and the physical age and condition in their proper setting; in other words, it gives us a mental photograph of the individual.

2. It enables the examiner to secure an insight into underlying motives.

3. It enables one to grasp the significance of behavior in relation to underlying motives or feelings.

4. It places prognosis as to future conduct, deportment, and economic efficiency on a firmer foundation.

5. It supplies suggestions as to tactful management and hints as to the amount of supervision advisable.

6. It points to the weak spots in character which may be strengthened or reconstructed by selected methods of training.

In preparing a guide for the study of the personality of the defective, I have taken advantage of the pioneer work on personality by Hoch and Amsden. Dr. Amsden is now continuing this work at Bloomingdale Hospital, and it is largely through his friendship and invaluable aid that I have been able to revise the present method of studying personality among mentally diseased patients to suit the needs of the feebleminded.

This guide[1] is formulated to assist in the study of the higher-grade defectives—preferably those with a mental age of seven or over. These are the types that present problems of adjustment not solely dependent upon intellectual capacity.

In devising this scheme, it seemed essential to give consideration to certain important side issues—namely, to limit-

1 See pages 492–96.

ing the amount of time required for its application and to putting it in such form that a concise, practical, and interpretative summary would be facilitated, without, on the other hand, detracting to any extent from its value as an exhaustive analysis of character.

To meet these requirements, the personality was dissected, as it were, into several components. These were as follows:

A. Intellectual characteristics
B. Sense of responsibility
C. Industrial efficiency
D. Output of nervous and muscular energy
E. Habitual reactions to inferiority
F. Sociability
G. Conduct and behavior
H. Mood
I. Reactions related to mood
J. Special aptitudes and interests
K. Unique and pathological traits

It was then possible to define two or more types with reference to each of these components, characterizing each type by a group of descriptive traits.

With such a scheme at hand, it is a simple matter to check under each division the types that describe the characteristics of any particular case, and, using this as a guide, to obtain a summary of the whole personality in a very short period of time.

Now, to take up the guide in detail, it is seen that Section A deals with traits of an intellectual nature. These traits serve as valuable adjuncts to the mental age. Although there are psychological tests for determining them in a laboratory fashion, it would seem advisable to note one's general impression in regard to them obtained from observation of the patient in his everyday, practical demonstration of them. In reference to these special traits, it was found that there were three different types of individuals possible.

In Section B the sense of responsibility is estimated. This, although in many cases dependent on intellectual ability, in

others seems to be more or less independent of mental age. It was possible to describe three different types of defectives under this heading—Type I, those who are actively irresponsible; Type II, those whose sense of responsibility is undeveloped and dependent on their intellectual defect; and Type III, those who have a fair sense of responsibility.

Section C deals particularly with the thoroughness and efficiency of the patient's industrial application. This is not wholly dependent on mental age, as it has been frequently observed that patients with the same intellectual level vary considerably in the matter of industrial efficiency. There were three types definable under this section.

Section D deals with those traits related to the output of nervous and muscular energy. These are quite important, as industrial efficiency is often more or less dependent upon them. They may also be modified by the prevailing mood. It was possible to describe four types here.

Section E evaluates one of the most important components of the whole personality. It deals with the reactions of the defective to his inferiority. The matter of individual inferiority is a weak spot with us all, as we all cling to the idea that we are born free and equal, with the emphasis on the equal. If one has a feeling of inferiority, irrespective of its origin, and irrespective of whether the inferiority be real or imaginary, one may react in one or more of several possible ways to it. These are indicated by the five types described in this section.

When we realize what the life of the average defective is, it is not unreasonable to believe that he has some appreciation of his inferiority. Whether he openly admits it or not is inconsequential. For that matter, it is not an outstanding characteristic of any normal individual to advertise a feeling of inferiority, if he perchance happens to be handicapped thus.

Another important consideration of the inferiority complex is that feelings of this sort may not only be hidden from outside recognition, but in addition not be accepted by the individual himself. When this happens, he may react in a com-

pensatory, defensive, or evasive fashion, as outlined in Types I, II, III, and IV under this section.

Under Section F, individuals may be classed in one of three ways in relation to their amiability and sociability. These more or less gauge the ability of the patient in his social adaptations.

Section G also deals with social adaptability, but more in relation to conduct and behavior. There are four different types of individual in this respect. In passing, it should be pointed out that it is essential for purposes of supervision and prognosis to estimate accurately what types, if any, of antisocial behavior are peculiar to any one defective. Such types are indicated in Types II, III, and IV.

Sections H and I deal with traits of considerable importance to social adaptation, behavior, conduct, and industrial efficiency. Section H includes six types of individual with reference to their prevailing moods. Section I is more or less dependent on Section H and comprises two types descriptive of reactions closely related to the prevailing mood.

Sections J and K, although of importance in selected cases, would not lend themselves to any distinct subclassification, due to the fact that there are so many possibilities. Under Section J a few hints are set forth which may be of value in indicating specialized educational efforts.

Under Section K are enumerated traits of an unusual or pathological nature that would tend to indicate a neurotic or psychotic state in addition to the initial intellectual defect.

The Guide

SECTION A

Traits That in a General Way Tend to Indicate the Subject's Intellectual Characteristics

Type I. Dull, slow to learn, no spontaneous interests, judgment and planning capacity poor.

Type II. Moderately alert, learns fairly easily, no spontaneous interests, judgment and planning capacity immature.

Type III. Alert, bright, quick to learn, spontaneously interested, good judgment and planning capacity.

SECTION B

Traits That Tend to Indicate the Sense of Responsibility

Type I. Actively irresponsible, heedless, contemptuous attitude. Unconscientious, not orderly, unwilling to be helped, heedless of the rights of others, and contemptuous of the usual standards of social and economic fitness.

Type II. An undeveloped sense of responsibility. Lacking in conscientiousness and unappreciative of the rights of others. An undeveloped sense of social and economic standards. Not unwilling to be helped, but unable to help themselves in any spontaneous, consistent, constructive fashion.

Type III. Fair sense of responsibility, conscientious, orderly, appreciative of the rights of others, and realizing the necessity of conforming to social and economic standards. Willing to be helped, and ever ready to take advantage of anything in order to help and improve themselves in a constructive way.

SECTION C

Traits That Tend to Indicate the Industrial Efficiency of the Individual

Type I. Thoroughgoing, steady, and persistent in application. Requiring more or less constant direction.

Type II. Thoroughgoing, industrious, steady, and persistent in application. Requiring practically no direction.

Type III. Superficial, careless, poor in application, and unsatisfactory even with constant direction.

SECTION D

Traits That Tend to Indicate the Amount of Nervous and Muscular Energy

Type I. Slow, deliberate, unhurried, with little or no initiative.

Type II. Inactive, sluggish, desultory, lazy, no initiative, and easily fatigued.

Type III. Active, energetic, quick, consistent, considerable spontaneity and initiative.

Type IV. Variable activity—at times sluggish and indolent, at other times overactive and tense. Active by fits and starts.

SECTION E

Traits That Tend to Indicate the Types of Habitual Reaction to Subject's Inferiority

Type I. Compensation-reaction type (boastful, expansive, overconfident, play for attention, trouble makers, sex and stealing delinquencies).

Type II. Defensive-reaction type (stubborn, unwilling to follow advice, sensitive to criticism).

Type III. Defensive-reaction type with secondary elaboration (paranoidal types, suspicious, discerning hidden motives, feelings of self-reference, mild persecutory notions).

Type IV. Evasive and neurotic-reaction type (hypochondriasis, sympathy seekers, capitalization of physical feelings and discomforts, blaming circumstances and others for own faults and mistakes).

Type V. Devoid of reactive tendencies, with the exception of a lack of self-confidence.

SECTION F

Traits of Especial Significance to the Individual in His Social Adaptation, with Particular Reference to Amiability and Sociability

Type I. Amiable, friendly, sociable, facility in making friends, gregarious.

Type II. Amiable, but reserved, slow to make friends, not actively gregarious, but yet not actively solitary.

Type III. Shut in, distant, unfriendly, self-centered, and actively solitary.

SECTION G

Traits of Especial Significance to the Individual in His Social Adaptation with Particular Reference to Tendencies Socially Unfavorable and Those Clearly Antisocial.

Type I. Quiet, well conducted, well mannered, respectful, coöperative, easy to get along with, no active delinquent tendencies.

Type II. Same as Type I., but in addition naïve and easily influenced or led into sexual discrepancies, stealing, or other antisocial behavior.

Type III. Boisterous, loud, ill mannered, difficult to manage, actively seeking delinquencies of a sexual or other nature.

Type IV. Ingratiating, cunning, deceitful, underhand, undependable, untruthful, with delinquent potentialities.

SECTION H

Traits Especially Related to the Prevailing Mood

Type I. Cheerful, and happy in a simple, quiet way.

Type II. Cheerful, and happy in an aggressive and spontaneously active way, heedless of the feelings of others and loudly and boisterously exuberant.

Type III. Phlegmatic and indifferent.

Type IV. Grave and serious, but not depressed.

Type V. Depressed, unhappy, and pessimistic.

Type VI. Variable mood. At times cheerful and happy in a spontaneous, aggressive fashion, at other times unhappy and depressed.

SECTION I

Traits of a Reactive Nature, but Closely Associated with the Prevailing Mood

Type I. Good sense of humor, even-tempered, stable, patient, and complacent.

Type II. Poor sense of humor, emotionally unstable, impatient, fault-finding, irritable, quick-tempered, sullen, and sulky.

SECTION J

Evaluation of Traits, Interest, and Aptitudes That, Owing to Their Intrinsic Nature, May Especially Favor Specialized Educational Efforts in Behalf of the Subject

1. From what does the subject get his deepest satisfaction?
2. What are his leading interests in work?
3. What forms of diversion, play, or entertainment most appeal to him?
4. Has he any special aptitudes?
5. Is he religious?

SECTION K

Unique and Pathological Traits

Odd or peculiar habits, mannerisms, episodic behavior, fears, doubts, compulsions, syncopes, stuttering, tics, abnormal dreams, somnambulism, delusions, and hallucinations.

ADDENDUM

In order to illustrate how a guide of this sort may be of practical value in assisting in the study of defectives, I shall cite just two cases.

M. J., a girl eighteen years old, has a mental age of nine years. She is alert, bright, quick to learn, is spontaneously interested, has some ability to plan, and her judgment is quite good. She is thoroughgoing, industrious, persistent in application, and requires practically no direction in her work. She has a good sense of responsibility, is conscientious and appreciative of the rights of others, realizes the necessity of conforming to social and industrial standards, is willing to be helped, and makes a good effort to help herself. She is deliberate, unhurried, and has a certain amount of initiative.

She is amiable, friendly, and sociable. In behavior she is quiet, well conducted, well mannered, respectful, coöperative, easy to get along with, and has no active delinquent tendencies.

As to mood, she is cheerful and happy in a simple, quiet way. She has a good sense of humor, is even-tempered, stable, patient, and complacent.

There seems to be no reason to believe that she would be unable to adjust herself to meet the demands of social and industrial life.

Another case, on the eleven-year level—a level that by itself would warrant the assumption that such an individual could do almost any sort of domestic work—is a girl nineteen years old.

She is uninterested, slow to learn, with poor judgment and planning capacity. In her work she is superficial, careless, poor in application, and unsatisfactory even with constant supervision. She is actively irresponsible, heedless, unconscientious, untidy, disregardful of the rights of others, unwilling to be helped, and contemptuous toward the usual standards of social and economic fitness. She is inactive, lazy, sluggish, desultory, and displays no initiative.

She defends her inferiority by a marked stubbornness and

unwillingness to follow advice, and furthermore unconsciously tries to excuse it by capitalizing her physical aches and discomforts in an evasive way. Her defense mechanism goes so far as to make her shut in, distant, unfriendly, and self-centered.

She is boisterous, loud, ill mannered, disrespectful, quarrelsome, uncoöperative, and definitely of a delinquent type. Together with this, she is more or less cunning, ingratiating, deceitful, and untruthful.

As to her mood, she is of a depressed, unhappy nature, with a poor sense of humor, emotionally unstable, quick-tempered, sullen, and irritable.

This description certainly makes it plain in what fields this patient's maladjustments lie.

Conclusion

In conclusion it is to be emphasized that this guide is designed not alone to classify or "label" the individual, but to supply information that may serve as a starting point or a working basis for constructive effort. Just what plan one may profitably pursue in any one case depends entirely in what sphere of the personality the defect lies. A sluggish, dull, uninterested attitude in a high-grade defective may indicate an underlying physical defect. A defensive type of reaction to an inferiority complex might suggest a management of the case planned to develop a certain amount of self-assurance and self-confidence.

It should be stated that practically all constructive efforts calculated to reinforce character defects of the mental defective have to be made through environmental changes, adroit direction, and habit training, rather than by direct discussion with the patient himself; the latter would resolve itself into a matter of futile efforts and misdirected energy.

It is clearly recognized that this scheme is beset by a variety of imperfections, which, however, may be ironed out by experience gained from its practical application. It is clear that knowing merely the mental age of a defective tells us little as to the possibilities of that individual. Whether he will be able to use to advantage what intelligence he has will depend upon other factors in his personality, and if this tentative guide helps to stimulate personality studies among the feeble-minded, it will have served a good purpose.

SOME OF THE PSYCHOLOGICAL MECHANISMS OF HUMAN CONDUCT*

IRVING J. SANDS, M.D.

Psychopathic Clinic, Bellevue Hospital, New York City

PHYLLIS BLANCHARD, PH.D.

Psychologist, Monmouth County Survey, Red Bank, New Jersey; formerly Psychologist, Psychopathic Clinic, Bellevue Hospital

UNTIL a comparatively recent period, the individual who showed aberrant behavior traits was looked upon as an outcast from the social group and was made to pay a heavy penalty for being different from his fellows. Within the last two decades, however, a radical change has taken place in the community attitude toward the individual who does not conform to its customs and standards of conduct. Two factors contributed more than any others to bring about this change. The first was the recognition of insanity as a form of disease and the equipment of hospitals for the care of the mentally sick. The second was the development of modern psychology, with its refutation of the old philosophical doctrine of freedom of the will and its conception of the human individual as an organism able to react only within the limits of instinctive, emotional, and intellectual endowment.

The scientific knowledge from both these sources has gradually been disseminated through the community and by a slow process of education has built up a change in the attitude of the group toward its aberrant members. In place of the old tendency to condemn and punish the psychotic, the psychoneurotic, the social radical, the laggard in school, the delinquent, or any other individual who did not strictly conform to social standards, there has come a questioning attitude, a tendency to wonder whether this atypical personality might be ill or mentally deranged, and a desire to know the cause of his peculiar behavior.

This new attitude of the community has placed upon the

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medical profession, particularly upon the neuropsychiatrist, increasing responsibilities. To him the community looks for guidance in the treatment of conduct disorders. He finds among his patients, in addition to the frankly insane and psychoneurotic types, an increasing number of individuals with delinquent tendencies, children who cannot get on in school, industrial misfits, and many other perplexing problems. Confronted with this wide variety of patients, the neuropsychiatrist has need of every available method of diagnosis and therapy. The neuropsychiatric problems created by the stress and strain of the situation in the late war brought home to every member of the profession a realization of the necessity for a knowledge of all the data that could throw light on behavior disorders, and a recognition of the inadequacy of knowledge of anatomy and physiology alone. In view of these new needs of neuropsychiatry, it is pertinent to consider how much information the new dynamic psychology offers that is relevant to these problems.

Many of the patients with whom the neuropsychiatrist is confronted and whose peculiar conduct he is asked to diagnose and treat are, of course, personalities of a definitely psychotic make-up, and present only a psychiatric problem. But many others are border-line cases, who can be treated intelligently only in the light of that broad understanding of human behavior which modern psychology offers. It is, therefore, relevant to the existing situation to summarize the psychological data on this point and to outline briefly some of the principles and mechanisms that would seem to govern human conduct.

At birth, the individual is equipped with certain innate tendencies to action. These activities are manifested in response to the proper situations, which may consist of either internal or external stimuli. These innate tendencies to response are not eradicable from the personality, but their form of expression is capable of modification. These inherited tendencies to response are the instincts, and their activity is always accompanied by an affective element known as the emotional reaction. Primarily, the instinctive and emotional responses of the organism are conducive to a state of pleasantness and a feeling of satisfaction and well-being, while the

inhibition or thwarting of these tendencies is a source of an unpleasant feeling-tone which tends to produce a general restlessness and sense of dissatisfaction. In obedience to this pain-pleasure principle, there is within the organism a natural tendency to allow free play to instinctive and emotional activities. But racial and individual experience have taught that even though the exercise of these innate tendencies may in itself be pleasurable, their uninhibited activity may be followed by exceedingly painful consequences. Thus the individual learns to subdue the desire for immediate pleasure in order to avoid the resultant unpleasantness, and learns to endure some painful circumstances in order to obtain a greater ultimate pleasure.

The repression of the instinctive and emotional impulses at their natural biological levels in obedience to the pain-pleasure principle may give rise to some important psychological mechanisms. The energy diverted from its primary motor expression flows over into other channels and produces other activities than those to be expected of the original tendency from which it is derived. It may find an outlet in various overt activities which become infused with an affective tone similar to that which would accompany the natural expression of the inhibited instinctive act. Or it may give rise to a train of imagery which forms dreams and daydreams, or becomes associated in literary form or in works of art. When the environmental situation offers no opportunity for adequate expression of the instinctive and emotional impulses, or when their expression results in too much pain, the daydream and fantasy become the chief method of response. This type of wish-fulfilment for the instinctive and emotional desires involves a flight from reality, in which the actual external situation is distorted or replaced by imaginary creations more in harmony with the desires of the personality. This flight from reality is seen in its extreme form in the mental mechanisms of psychoneurotic patients and even in some of the delusional and hallucinatory experiences of patients with psychoses.

The instincts and emotions with which the human individual is endowed, and which operate in his behavior, subject to the laws of pleasure and pain, would seem to be of three main

types. The first type may be said to include those activities which tend to preserve the individual. These consist of three instinctive tendencies with their concomitant emotional reactions:

1. The instinctive tendency to seek food and the feeling of hunger.
2. The instinctive tendency to flee from dangerous situations and the emotion of fear.
3. The instinctive tendency to fight and the emotion of anger.

The second group of instinctive and emotional reactions is composed of activities that tend to racial preservation. These are also threefold:

1. The reproductive instincts and the sexual emotions.
2. The parental instincts and emotions.
3. The gregarious instinct (the tendency to act like other members of the group) and the emotion of the herd.

The third class of instinctive activities may be characterized as those that aid the individual in adapting himself to his environment. These are:

1. The instinct of manipulation and the feeling of curiosity.
2. The instinctive and emotional responses included under the term play.

The food-getting instinct is the first to manifest itself in the life of the individual. The infant comes into the world with the sucking reflex ready to function. This is the earliest activity that occurs, aside from breathing and the other vegetative functions of the organism. The first recognition of the mother is as the source of food. The mother becomes a food symbol to the infant by the same conditioned-reflex mechanism that Pavlov found in his experiments with animals. The importance of this bond for the later development of the child cannot be overestimated. Throughout childhood the mother is normally the source of food and protection and is thus the object of a peculiar attachment. During adolescence this attachment must be gradually dissolved before the individual can enter upon the normal independent existence of the adult. Thus at this stage of the child's life there develops an ambivalent feeling toward the mother, composed of a desire to remain within the sheltering maternal circle and an oppos-

ing wish to escape the domination of the mother and achieve freedom for the personality.[1]

The economic and sociological implications of the food-getting activities of man are manifold. Hunting, fishing, agriculture, barter and exchange, all grew out of the necessity of obtaining food. Hunger played so important a rôle in the life of early man that it molded his religious rites and ceremonies. As the primitive conception of God grew out of the matrix of man's own feelings and desires, so he pictured his deities as demanding sacrifices in the form of food. The influence of hunger can be seen in modern times in the attitude of the conquered European countries toward their more prosperous victors. The necessity of obtaining food from the former enemy is stronger than hatred and the desire for revenge.

After the early manifestations of the food-getting instinct, the next instinctive reactions to appear in the child are those of fear and anger. Either one of these reactions may be incited by similar situations. Whether the individual responds to dangerous stimuli by avoiding reactions or aggressive behavior is dependent in part upon his own physiological condition, personality make-up, and previous experience, and in part upon minute variations in the stimulus situation. The child who is born with some organic deficiency is apt, as he grows older and becomes more self-conscious, to be fearful in attitude because of the feeling of inferiority that his biological insufficiency naturally induces. This sense of inferiority is increased or decreased according to the treatment that the child receives at the hands of his parents and other associates. If the parents and teachers prove critical of all his efforts, the feeling of inferiority is deepened and there is a tendency to become afraid in all situations. But if parents and teachers encourage wisely, the feeling of inferiority may be somewhat overcome and the child may learn to attempt to master the difficult situation instead of fleeing from it.

Very often the feeling of inferiority carries with it its own antidote, for there is a tendency to attempt to rid oneself of this unpleasant feeling by making every effort to demonstrate

[1] This is well brought out in Björkman's *The Soul of a Child*. New York: Alfred A. Knopf, 1922.

one's superiority over one's fellows and over environmental difficulties. In other words, the individual compensates for his fearfulness and sense of inferiority by the development of a superimposed aggressive attitude. This psychological mechanism has been amply described by Adler, who characterizes it as the feeling of inferiority and compensatory will to power. The will to power may become so strong in the individual as to dominate his entire behavior. It is frequently seen in persons who are placed in authority in political, educational, and industrial fields, being manifest not only in their struggles to obtain such positions, but also in their attitude toward subordinates and even toward those who have been instrumental in securing them their authority.

Under extreme stress of circumstances, these compensating mechanisms break down, and there is a reversion to a type of conduct in which there is complete fear control. This was well demonstrated in the war neuroses, in which the fear of impending danger could no longer be repressed and the reaction became such as would insure the individual's removal to a safer place.

Fear has held an important place in the social life of man. The taboo control of the primitive group was based almost entirely upon this motive. Religion, in its earliest stages, had its genesis in fear. Primitive man had a spiritistic interpretation for all natural phenomena that he did not understand, and his desire to propitiate these forces was born of terror. The laws and religious beliefs that grew out of these primitive taboos and superstitions held no less an element of fear. Modern society is also dependent to a great extent on fear control.

Although anger is in a sense an ambivalent reaction to fear, in that the first fear response to a situation often tends to pass over into anger and aggressive behavior, it has not been so powerful an influence as fear in the development of the individual or of the race. The activities of man have been prompted by the desire to escape from fearful situations much oftener than by anger. Fear of punishment has been one of the strongest motives controlling the criminal passions of mankind. It has been a dominant factor in the relation of individuals and of nations. Fear of destruction has prompted

manipulation of the environment to make it more suited to men's needs. Although it has thus been an incentive to force humanity on the path of progress, it has also been at times an obstacle to social evolution. The fear of becoming a social outcast through difference from other members of the group may quite easily act as a check to inventive genius, and in this manner retard the advancement of civilization.

Powerful as are the self-preservative tendencies of hunger and fear, the racial instincts are no less important motives of human conduct. It was not until the work of the psychoanalytic school that the full implications of these tendencies became known. To the psychoanalysts belongs particularly the credit for investigations that resulted in new and enlightening knowledge of sex psychology. Previously, sex had been considered as of comparatively late development in the instinctive and emotional life. But psychoanalytic studies have shown that this instinct has manifestations even in the infancy period, and that many of the sexual abnormalities of adult life are due to regressions to these infantile erotic traits or to failure of proper development of the erotic tendencies. The polymorphous-perverse tendencies of the child's sex life and their relation to sexual pathology in adults have been discussed at length by Freud and his followers and need not be entered into in detail here.

The sex instincts and emotions have played an important part in the cultural history of the race. Social customs and religious observances have always united to enforce the repression of the sex life at its biological level, except within certain sanctioned limits. Many of the primitive taboos grew up in the attempt to subordinate the sexual desires of the individual to the demands of the group. The energy thus prevented from its natural outlet found substitute expressions in reinforcement of activities along other lines. In those gifted with special abilities, the sexual cravings found expression in the arts. Musical rhythm, picture making, dancing, folklore, all received a strong impetus from repressed erotic desires which found partial fulfilment in these vicarious activities. Modern art and literature offer no less a means for gratification of the sexual cravings repressed along biological lines.

While repression of the sex tendencies has thus been of

some advantage to the race in that it subserved the interests of art and culture, in the life of the individual it has often proven injurious. From mere daydreaming and sexual fantasies to incapacitating neuroses, the repressed sexual desires impair the physical and mental efficiency of those who lack special abilities that would enable them to sublimate their sexual cravings along useful lines. Even antisocial traits, from mere perversion of the natural biological instinct of sex to conversion of its energy into pathological lying and stealing or into sadistic outbreaks that may sometimes end in murder, may be traced to abnormal development of this instinct, or to its failure to find normal or sublimated expressions.

The knowledge of sex psychology which has led to the understanding of its influence in the history of the race and of the individual has also led to a relaxation of social control in this field. The group is gradually becoming more tolerant of the member who deviates from its sexual customs. This is well shown in the change in attitude toward the unmarried mother and her child. Where once these unfortunates were considered beyond the pale of social recognition, there has been a steady movement toward their reinstatement which has even found expression in legislation for the purpose of legitimatizing the child born out of wedlock. The old ascetic ideals, which tolerated the sexual instinct only in the service of reproduction, are losing their hold, so that such topics as birth control are more or less freely discussed and legislation permitting the dissemination of this knowledge is openly advocated.

The parental activities are by their very nature closely connected with the reproductive instincts. Home-building grew out of the necessity of providing shelter for the mate and the child. The first social unit was probably the family group and the clan. Many personal sacrifices are made in obedience to the promptings of the parental motives. These sacrifices are facilitated by the very nature of the instinct. The parent unconsciously identifies the self with the child, as a part of that striving for perpetuation which is also expressed in the belief in immortality. This identification with the child is useful in so far as it causes the parent to subserve personal interests to those of the offspring. It is detrimental when the parent

forgets that the child has a separate individuality, and attempts to interfere with the natural developments of its personality. Therefore, although the self-identification of the parent with the child is advantageous through the infancy period and early childhood, it is handicapping in the later years of adolescence, when the child should be permitted to work out its own vocational interests, friendships, and emotional attachments.

There is indeed no other single factor that has so much influence on the development of the personality as the parental environment. On the attitude of the parents, the child models not only his reactions to them, but to the rest of the world. The father who assumes a dominating attitude toward his children causes them to become antagonistic not only to his rule, but to all other forms of authority, so that their attitude toward the school, the church, and the whole social organization is apt to be decidedly defiant. On the other hand, the father who is too tender with his daughters may develop in them a fixation on himself that will prevent the transference of their affection at the proper time for mating, or will cause them to select a mate possessing traits like the father's, regardless of suitability in other respects. So, too, the mother who lavishes an undue amount of love and caresses on the son binds him to her with ties that prevent a normal functioning of his mating instincts in later years. Too much maternal affection is harmful to both sons and daughters in another respect, as it is liable to interfere with the development of self-reliance and render them unfit to meet the situations of adult life upon their own initiative and responsibility.

The wise parent, therefore, must learn to check the emotions that would prompt him to love his children too intensely, or to manifest his affection in ways that protect the child for the present moment, but leave him more open to injury at some later date when the parental shelter is no longer at hand and when he is confronted with situations that call for training in independent judgment and self-reliance. Moreover, the parent must forego the joy of seeing the children accomplish those things which he had hoped to do himself, and allow them to seek out for themselves the vocations and avocations to which

they are best adapted. These are the real sacrifices which the fulfilment of parental duties requires.

The herd instinct is the impulse to be with one's fellows, to act and even to think as they do. One of the chief causes of unhappiness is the feeling that one is set apart from one's companions by some peculiar characteristic. It is to the desire to conform to the group standard as much as to fear that we owe obedience to social laws and customs. Exclusion from the group has long been the accepted punishment for those who transgress its laws, and this exclusion forms the basis of the modern criminal code.

It was the operation of the gregarious instinct and emotion that united the family groups into larger communal organizations. These larger groups were superior to the family in hunting, in warfare, and in many other activities of importance for survival. But although gregariousness was of vital importance in the history of the race in this manner, in other ways it tended to impede progress by suppressing individual differences and by forcing the genius to conform to the group average. Thus not only were criminal tendencies suppressed in favor of the group, but creative faculties were also subordinated to this tendency to regard with suspicion any deviation from the norm. The great leaders of religion and science were often persecuted because they aroused the instinct of the herd by their deviation from the mass.

The unreasoning nature of the gregarious impulse can be seen equally well in modern life. Enthusiasm for the late war was in large measure created by propaganda appealing to this emotion. At the present time the country is just as eager to hold conferences in the interest of preserving peace. Just as, "Make the world safe for democracy!" was formerly the voice of the herd, so now its cry is, "Save the world by disarmament!"

The development of the hand in the higher primates and in man has been accompanied by what would seem to be an instinctive tendency to handle the objects of the environment, to twist them into various shapes, and to put different objects together to form new ones. It was this manipulative activity that was the source of the earliest inventions of mankind, and it is the more complex expression of this instinct that has

produced the miracles of modern civilization. The emotional impetus back of these manipulative activities is curiosity. The desire to discover new laws and invent new methods of control is the spirit of scientific research. Modern scientific medicine owes its existence to the workings of this form of curiosity.

The manipulative activities are pleasurable so long as they are utilized in the service of the spirit of curiosity. When they become routine in nature and offer no further satisfaction for this emotion, they become automatic rather than instinctive in character. Work performed at this lower level lacks interest and often assumes an unpleasant affective tone. Modern industry for the most part demands only routine labor and in this respect, as in many others, is ill suited to human emotions.

Although there is much discussion as to whether play is really instinctive, the consensus of opinion considers that there is a natural tendency for the surplus energy of the organism to flow over into spontaneous activities known as play. In play, the individual repeats the history of the race. The boy who goes hunting and fishing is repeating the story of his ancestors. At the same time that play recapitulates ancestral experience, it prepares for the serious duties of life. The girl playing with her doll is not only mothering it as women have mothered their infants from time immemorial; she is also developing tendencies that will be useful when she actually becomes a mother.

Group play inculcates in the participants a spirit of fairness which has a strong influence on the development of ethical relationships in general. Fair play is a slogan in every field of human endeavor. International sports, such as the revival of the Olympic games, tend to remove racial prejudices and antagonisms and to promote better understanding between nations. They are perhaps more effective methods for promoting peace than conferences and secret treaties.

Although these instincts and emotions which are inherent in human nature have been described separately, it must be borne in mind that they do not act alone, but in antagonism to or in reinforcement of one another. It is obvious that in situations of a nature to rouse both fear and anger, one mode

of response must be suppressed in favor of the other. It is impossible for the individual to flee and to fight at the same time. Again, fear unquestionably inhibits sexual expression.

On the other hand, many of the complex activities of the organism are the result of the synchronous operation of two or more instinctive and emotional tendencies. If we analyze such an activity as home-building, we shall find an interaction of the parental and reproductive instincts, plus fear in the form of the desire for self-preservation. In that ordinary social activity, the dance, there is opportunity for the exercise of the tendencies of play and gregariousness and of sublimated sexual impulses. In war, the instinct and emotions of the herd hold sway, together with fear and anger in an ambivalent relationship in which first one and then the other finds expression in overt action. The fear of group destruction is a powerful incentive in rousing the instinct to fight. A more remote motive of war is that of food-getting in its economic aspects. Economists and sociologists have repeatedly pointed out that scarcity of food supply is one of the chief causes of war. Many other human activities could be analyzed into their component instinctive factors in this manner.

Upon the nature and interaction of the emotional responses the personality of the individual depends to a great extent. Personality is the aggregate of the physical and mental characteristics that enable the individual to respond in a characteristic fashion to a definite situation, and that distinguish him from others and give him his own peculiar individuality. In the so-called normal personality, these various instinctive and emotional impulses are fairly well balanced, so that demands for adjustment to new situations are met in an adequate and socially approved manner. In other personalities, there is an imbalance of the emotions, so that response to necessities for adjustment are determined by inadequate or over-accentuated affective responses rather than by the exigencies of the external situation. When the imbalance of emotions becomes extreme, we have the neurasthenoid, manic, depressed, or schizophrenic personalities familiar to those acquainted with mental disorders.

Just as the relative strength and intensity of emotional reactions vary in different individuals, so there are infinite

gradations of intellectual capacity which are a part of the original equipment. The human individual is born with a definite neural structure which determines the limitations of his mental development. Except in cases of destruction or interference with the functioning of the brain cells by injury or disease, the innate intellectual potentialities of the individual undergo no changes, but remain throughout life at the level fixed for them at birth. This native capacity determines how much each individual will be able to profit by his educational opportunities and environmental experiences, but no matter how great the advantages offered, they cannot be of benefit once the limitations of this innate endowment are reached.

These variations in intellectual equipment range all the way from the complete idiot who leads a vegetative existence and the low-grade imbecile who learns to pronounce a few words without conception of their meaning, through border-line types and individuals of average intelligence, to the genius, who, because of his special abilities, is far beyond the reach of his contemporaries. Society is composed of these various intellectual strata, which merge imperceptibly into one another. Yet for the most part society takes no account of these individual differences, but expects from every member of the group the same standard of educational attainment and equal civil responsibility.

In addition to variations in general mental endowment, there are individual differences in special abilities and disabilities. Persons of average general intelligence may be endowed with some special ability, such as superior manual dexterity, exceedingly vivid auditory or visual imagery, unusual verbal imagery resulting in superior language expression, and the like. By these special qualifications they are enabled to attain heights of achievement otherwise beyond the reach of their intellectual level. On the other hand, there may be special disabilities inherent in the mental make-up, which prevent the individual from utilizing his general intellectual endowment to its full capacity. Special disabilities in reading or arithmetical processes, for example, are a great handicap to the child under the present educational system, while these and

other disabilities limit the vocational possibilities to a considerable extent.

Although the intellectual equipment and special abilities and disabilities are of extreme importance from the viewpoint of educational methods and vocational guidance, they are of much less significance in the control of behavior than the instincts and emotions. With the enthusiasm that accompanied the development of tests for the measurement of general intelligence and the detection of special abilities, there was an attempt to correlate these qualities with behavior traits and types of conduct. Because a certain number of mental defectives were found among the criminal and delinquent classes, the statement was often made that mental deficiency was one of the chief causes of criminal conduct and immorality. Conversely, there has more recently been an effort to show that a positive correlation exists between high intelligence and morality. The fallacy of these deductions lies in the fact that they are based on statistical data gathered from highly selected groups. If we should make similar studies of a section of the social group which would include all classes, it is probable that we should find behavior traits much more highly correlated with innate instinctive responses and conditioned emotional reactions than with intellectual endowment. It must be borne in mind that a person of high intelligence is more clever at concealing aberrant conduct, and that he is, therefore, not so likely to come into the hands of the law as the less intelligent delinquent. Moreover, the intelligent criminal may limit himself to the direction of operations, detailing to his underlings the actual measures liable to result in arrest and imprisonment.

It is probably true that intelligence becomes a contributing factor in the production of moral conduct in that the person of intelligence can foresee more clearly than the defective the results of acts that are socially condemned. But in the face of intense emotional reactions, this foresight does not alter behavior to any marked degree. The university professor makes love to his pretty student in spite of the knowledge that it may mean loss of academic standing. The business man is harsh to his employees because to lord it over them removes

his feeling of inferiority, although every dictate of intelligence counsels that a friendlier attitude on his part would be conducive to more loyal relations and better workmanship. In opposition to the defective delinquent, who is exploited in recent literature concerning the criminal type, there is the equally feebleminded individual who is one of the most docile members of the group, who is a faithful attendant at church and whose morality is above reproach. This latter type conforms to social standards, not from any intelligent appreciation of right and wrong or from any foresight as to the advantages to be derived thereby, but simply because his emotional make-up and training have been such as to mold his reactions into a stereotyped form of response. Many industrial organizations prefer the high-grade-moron type of employee because of his greater obedience and general docility.

Sexual immorality in women has been used as an outstanding example of the tendency of feebleminded individuals to show delinquent traits. When this statement is based on statistics concerning unmarried mothers, it is readily perceived that the material studied is not relevant to the proposition. The lack of intelligence recorded in these unmarried mothers was not in any sense a motive of their conduct, except as it rendered them more open to suggestion and less aware of the consequences of their act, or lacking in knowledge of methods of avoiding the unfortunate results. Feebleminded-ness is a contributing factor in the making of the prostitute to the extent that it may render her less able to make her living by other economic means. Emotional instability is a characteristic of the prostitute as often as mental defect.

In the final analysis, we shall find that an understanding of all problems involving conduct, whether of the group or of the individual, is founded primarily upon a knowledge of the instincts and emotions. While other factors enter somewhat into the picture, they are relatively of much less importance. History itself is only to be comprehended in its real import in the light of this knowledge. The great movements of every age spring out of the emotional life of the people. Industrial unrest is due in large measure to the failure of adaptation of the modern economic system to the emotional life of the laboring masses. Not only does the division of labor implicit in the

factory system result in the reduction of workmanship to the performance of simple automatic acts which are accompanied by no feeling pleasanter than that of fatigue, but also it thwarts the instinctive and emotional cravings of the personality in other ways. The transitoriness of labor precludes the possession of a permanent home and sometimes interferes with mating activities. The wage system divides workmen and factory owners into two distinct classes in outrage of the gregarious desires which impel the laborer to long for the same type of life that he sees going on above him. The whole industrial system necessitates the constant repression of the instinctive and emotional life of the workers, and thus causes a sense of dissatisfaction and a general restlessness which are expressed in strikes and similar manifestations.

While the new dynamic psychology, with its explanation of human behavior as primarily the expression of instinctive and emotional tendencies, affords an interpretation of the general activities of mankind, its application to the concrete problems of neuropsychiatry is our chief concern. As has been stated, the neuropsychiatrist no longer limits his sphere of activity to physiological disturbances resulting from structural changes in the nervous system and to the so-called functional psychoses and psychoneuroses. He is also called upon to explain conduct disorders consisting of maladjustments at school and at home, industrial misfits, antisocial behavior, and the like. There are certain definite psychological principles that assist in the diagnosis and management of these cases.

After the medical and neurological status of the patient has been established, the family and personal history are studied in the light of our knowledge of the psychology of instincts and emotions in an attempt to determine the specific motives of conduct in this particular case. In dreams and daydreams we have a further clue to these motives. In dream and fantasy we find an actual or more often a symbolic expression of the instinctive and emotional cravings that are predominant in the life of the individual, but that do not always find a natural expression and gratification. In some instances, the long-continued denial of the natural outlets for these cravings results in the establishment of substitute modes of response which are symbolized in the dream, but pass over into overt action in

the very antisocial form of behavior that the neuropsychiatrist is called upon to explain. When these vicarious expressions become the habitual reaction patterns, they serve to divorce the individual from reality to a certain degree. Daydreaming offers a particularly facile method of escaping reality and finding satisfaction in fictitious experiences created by the imagination. From the daydream to pathological lying is only a step, and very often the fantastic tales of the pathological liar will be found to be simply an outgrowth of this habitual flight from reality. Thus the task of the physician often becomes that of leading the patient back into contact with reality and imbuing him with the courage to face the actual situations of life and adjust his responses to them more appropriately.

In other cases, we find that the emotional life has been modified by the environmental factors of childhood experience to such an extent that the whole reaction pattern of the individual has been determined thereby. The influence of the parental environment in determining the manner of response to other situations has already been referred to. The child tends to respond to those with whom he comes into contact in accordance with their resemblance to the father and mother type. Emotional fixations are carried over onto the teacher who resembles the beloved parent, while the disobedient and intractable pupil may be only expressing antagonism toward one of the parents for whom the teacher has become a substitute. Dislike of parental authority may also be expressed in antagonism to social authority and give rise to antisocial acts. The neuropsychiatrist will find the key to much delinquent conduct, as well as to many problems of school maladjustment, in emotional responses thus conditioned by the family situation. Very often the patient is unconscious of these influences that have warped his emotional life, and it then becomes the task of the physician to enlighten him as to the true significance of his conduct.

Emotional disturbances related to the sexual life are frequently a cause of delinquent conduct. The simplest form of these are the perversions, such as exhibitionism, assault of children, sadistic crimes, and the like. Unsatisfied curiosity regarding sexual matters is a source of emotional conflict in

many instances. Reveries and speculations concerning the nature of the relationship between the sexes is often the beginning of a habit formation that results in pathological lying. The false accusations of hysterical girls, which have no foundation in actual experience, are fantasies growing out of imperfect knowledge of sexual relations and offering a direct wish-fulfilment of unconscious sex desires. By a process of association and substitution, stealing often becomes a vicarious means of sexual gratification. Suggestions to sexual practices and to stealing often come from the same source and at about the same time. In many instances, the sexual temptation offered by bad companions is resisted, but the associated activity of stealing receives the emotional content and becomes a substituted outlet.

Perhaps the individual brought to the neuropsychiatrist may have a marked feeling of inferiority for which he is compensating by his peculiar behavior. The endeavor to remove the feeling of inferiority spurs some individuals to intellectual achievement, so that they become the leaders of their class in school and later make brilliant contributions to the arts and sciences or to social and political movements. On the other hand, the attempt to compensate for the feeling of inferiority may be by means of assuming the leadership of gangs and unruly organizations, and by expressing defiance of authority. It is indeed a distinction to be notoriously bad and thus to be raised from the realms of mediocrity. If the individual has sufficient intellectual potentialities, he may be guided into ways of satisfying the will to power better adapted to social requirements.

Emotional conflicts may be manifested, not only in antisocial behavior, but also in innumerable somatic symptoms, either alone or in connection with antisocial traits. Nail-biting, choreiform movements, wringing the hands, tearing the hair, picking the nose, headache, dizziness, visual and auditory disturbances, nausea, vomiting, retching, belching, frequent micturition and defecation, enuresis, sphincteric disturbances, cardiac palpitation, respiratory disturbances, all kinds of tics, transitory paralyses, and various sensory disturbances are sometimes due to emotional conflicts. When this is the case, the somatic symptoms tend to disappear with

the solution of the mental conflict and the readjustment of the individual.

Although a knowledge of the psychological mechanisms of conduct will aid the neuropsychiatrist materially in his work, and although he will find these principles the outstanding facts in the etiology of many of his cases of conduct disorders, he must always be on the alert for incipient psychoses which may also be a cause of peculiar behavior. The hypomanic disregards authority because his continual flight of ideas and constant psychomotor pressure prevent him from focusing his attention on the environmental situation sufficiently to grasp its full implications. The dementia-praecox individual reacts to the images of his own delusions and hallucinations instead of to external stimuli, so that his behavior is out of harmony with the circumstances of his environment and may even be antisocial in character. The paretic, especially at the onset of his illness, not infrequently commits gross antisocial acts that are of serious consequence, not only to himself, but also to his family. Arteriosclerotics and seniles not only show marked memory and retention defects and deficient processes of perception and association, but also become very irritable, react in a more or less paranoid and delusional manner, and come into conflict with established laws and conventions. Epileptics, before or more often after seizures, often commit serious offenses, such as setting fires, stealing, sexual assaults, and even murder. Those epileptics in whom the disease manifests itself in the form of psychic equivalents are particularly liable to get into difficulties because the confusion and bewilderment that accompany these equivalents cause a total disregard of reality. Psychiatric studies in criminology have contributed more than any other single factor to the humane treatment of the criminal. The scientific contribution of psychiatry in this field has influenced the attitude, not only of the legal profession, but also of the intelligent layman, so that the whole problem of punishment is approached from a different point of view than was formerly held. The result of this attitude is apparent in modifications of the penal code and in the reform of the prison system and prison discipline.

The management of the psychoses is a medical problem with which the neuropsychiatrist is fairly familiar and which needs

no elaboration in this paper. On the other hand, the management of conduct disorders having their origin in abnormalities or disturbances of the instinctive and emotional life is directly correlated with the psychological principles which we have been discussing, and requires a brief presentation. The guiding principle in these cases is the substitution of socially adapted forms of response for abnormal or antisocial behavior. If it is impossible for the instinctive and emotional life to function at its natural level, its energy must be secured an outlet in activities that do not bring the individual into conflict with group standards and that are preferably of some advantage to the group. This necessitates a careful inventory of the potential capabilities of the individual, and a skilful manipulation of the environment to afford an opportunity for their utilization.

Applied psychology has devised a series of mental measurements which include tests both for the estimation of the general intellectual capacity and for the detection of special abilities and disabilities. These tests are of inestimable value in furnishing a more exact knowledge of the possibilities of the individual than can be acquired by any other means. Such knowledge is indispensable in the selection of the proper field for the transference of the energies from antisocial to socially adapted activities. It would be useless to expect the moron to sublimate his instinctive and emotional impulses in the same fashion as the individual highly gifted along artistic or literary lines, and it would be equally foolish to expect either a subnormal or a superior type to conform to the standards of the group average.

The psychologist who is familiar with mental measurements by virtue of his training and experience is best equipped to apply these tests and interpret their significance. The neuropsychiatrist is usually insufficiently trained in the technique of mental testing, on which the accuracy of the test so largely depends. On the other hand, the psychologist must attribute meaning to his results in the light of medical and psychiatric findings, and in accordance with the emotional state of his subject. Therefore, the welfare of the patient demands the coöperation of the neuropsychiatrist and the psychologist. Specialization and division of labor are advantageous in this

field as elsewhere. It requires approximately an hour to determine the intelligence level of a single individual with any degree of accuracy, and additional time is necessary for the study of special aptitudes and inclinations. Even if the neuropsychiatrist were highly trained in the methods of psychological technique, his time would be absorbed in work that is a more direct expression of his real interests.

After the functional capacity of the individual has been determined by careful studies of hereditary and environmental influences, physical make-up, personality traits, intellectual endowment, and emotional responses, it becomes necessary to manipulate the environmental situation to provide opportunity for the utilization of this capacity to the best advantage. Wherever possible, the services of the social worker trained in psychiatric problems can be used to advantage in effecting environmental adjustments. The worker can go into the home, not only for the purpose of evaluating the family situation, but also to offer suggestions at the direction of the psychiatrist for adapting the home life to the needs of the patient. Sometimes a change of occupation will be found necessary as a therapeutic measure, or the teacher may need to be advised concerning the personality of the pupil and the desirability of more lenient disciplinary measures or the most effectual mode of handling this particular child. Sometimes it may even be well to remove an individual from his environment and place him in better surroundings. There are innumerable ways in which the environment may be modified, and the social worker is able to aid materially in the amelioration of conditions.

Since the trend of modern medicine is toward preventive measures, it becomes necessary to consider the possibilities that the utilization of the principles outlined in this paper offers for mental hygiene. Perhaps the greatest contribution of modern psychology is its discovery of convincing evidence of the importance of the infancy period and childhood. It is during these early years that the reaction patterns become relatively fixed to form the life habits of the individual, and it is at this time that measures should be instituted for the development of socially adapted responses and the prevention of improper reactions. This can best be accomplished by the

addition of mental clinics to the school organization.[1] It is obvious from the preceding discussion that the personnel of such clinics must include the services of the neuropsychiatrist, the psychologist, and the psychiatric social worker.

The activities of the mental clinic in connection with the school would embrace the following:

1. The recognition of somatic disease and incipient psychotic disorders.
2. The recognition of mental defectives and the arrangement of a modified curriculum suited to their capacities.
3. The recognition of the superior child and adequate provision for the development of his special abilities.
4. The recognition of special vocational aptitudes and advice concerning their utilization.
5. The guidance of play to inculcate the qualities of fairness and sociability.
6. The study of children showing delinquent tendencies and other conduct disorders.
7. The study of environmental influences and the readjustment of the environmental situation for the benefit of the child.
8. The study of problems due to adolescent transitions, and advice concerning these difficulties.

Thus the work of the mental clinic becomes that of an adjusting unit which has for its function the adaptation of the individual in harmony with an understanding of his needs and the requirements of society. It is obvious that juvenile courts, orphanages, and other institutions dealing with children require the services of the mental clinic as much as the schools. Modern industrial organizations, courts of justice, and penal institutions could also profitably employ such an adjusting unit. While it must be admitted that modern industry is not primarily adapted to human needs, it must also be admitted that a certain percentage of disgruntled and dissatisfied employees are simply vocational misfits or are maladjusted in some other way that could be corrected by the adjusting unit.

[1] Not alone the grammar and high school, but the college and university as well, where such facilities should be available in connection with the department of student health.

The court can never satisfy the demands of justice without the employment of such a unit because many of the cases that come before it are medico-psychiatric rather than legal problems. The prison and reformatory are dependent upon the adjusting unit for the classification of inmates, the administration of proper disciplinary measures, and the institution of training that will provide for the rehabilitation of the individual by furnishing him with occupational training and socially adapted ideals.

Even from this inadequate resumé, it is apparent that modern psychology has data to offer that are of importance for the understanding of human conduct and that are applicable to the problems of neuropsychiatry and mental hygiene. It must always be remembered, however, that psychology is a comparatively new science, and that dynamic psychology is of extremely recent origin. Moreover, in dealing with the human individual, it is dealing with an exceedingly variable factor, so that the principles of human conduct cannot be applied with the same rigidity as the laws formulated by the more exact sciences. Therefore, we must remain open-minded toward the efforts of earnest workers in this field, even though their findings do not always agree with our own preconceived ideas. Even where our psychological knowledge is insufficient to explain some particular behavior problem, it should at least create in us a tolerant attitude toward aberrant members of the group and impel us to withhold judgment until further scientific investigation has increased our knowledge in this field. It also becomes imperative for those who are trained to understand the mental mechanisms underlying human conduct to take an active part in civic life, so that social laws and institutions may be better suited to the real needs of the human individual.

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INTERNAL SECRETIONS AND THE HOME

EARL D. BOND, M.D.
Department for Nervous and Mental Diseases, Pennsylvania Hospital

INTERNAL secretions, we are told, are the things that shape our characters. Horatius held the bridge because inside of him secretion *a* was able to overwhelm opposing secretions *b* and *c*.

As the Puritan home seems to have been a place where character was formed, so the modern home seems by all accounts to be the place where character is needed. Accounts agree as to essentials. The home is entered in the evening by a man looking forward to food and a quiet place, a man who is tired and irritable, but who does not want to be left alone—he wants a bland companion. His wife is not usually that: she has occupied a lonely house and has acquired a longing to go out that, unappeased, brings irritability. During the day her suppressed desires to meet people bring about convictions that she must make people better. The fact that these convictions change is rather annoying to her husband, who any way is in far from a reforming mood as he settles to the evening paper. In and out of the home breezes a daughter, vigorous, bossy, irritated by delays, talented. She has tried, in order, music, nursing, art, literature, and social service, but has balked successively at finger exercises, bed making, mechanical drawing, and grammar. There is still a chance that social service will give her energies an outlet without preliminary drudgery. A son is flippant, apparently lazy, altogether unknowable, fussy. And the picture as drawn for us includes an Aunt Sally, inheriting her ideas from an earlier generation, who helps with an unselfishness which at times is hard to bear. The whole family has the unhappy knack of being greatly disappointed by very trifling things. With a disinclination to be bound by custom or authority, they must in the midst of the game pause to wonder what the rules are, and the uncertainty does not help them to get on with one another.

Now think of this home in terms of internal secretions. If each member of the family has a number of glands which by very complicated responses pour their very much mingled secretions into the blood to constitute an end result which is his character, we have a very precarious state of things. But the precariousness contains in itself a promise. "The pituitary controls . . . the rhythm of poetry and music, punctuality, neatness, order." If John persistently comes late to school, give him pituitary. "The anterior pituitary . . . is concerned with that maturity of mind and with that judgment which in most men act as restraining factors to the coarser instincts." For immaturity of mind give more pituitary. Why not strengthen the family by glandular therapy, subtracting from Aunt Sally that super-unselfishness which is so trying in a home and adding the same trait to her niece, in whom it could hardly cause trouble?

Just here we come upon one of the most satisfactory things about the internal secretions. They can be measured to the thousandth part of a cubic centimeter. How immeasurable the forces that hitherto have been used to develop character! Expose a man to religion in order to make him a more conformable part of society and suddenly he becomes a prophet who not only will not let us rest in peace, but is more nonconformist than ever. Think of the distress of a family watching a spark of decency, which for its own purposes it has given its oldest son, being fanned to a divine and uncontrollable fire. And there are always Kate Negleys who take religion hard and insist on being "as wholly sanctified as they make 'em" and "hunting the Scriptures for things you mustn't do". Nor has any one been able to predict what education would do to a man. And how does one handle a patriotism once roused?

But the future molder of men can turn with relief to very exactly weighed capsules filled with the substances of different glands. Beginning with one-eighth of a grain, the dose can be run up a ladder of infinite and exact gradations. Not only that, but if one overshoots the mark through carelessness, one can counteract ill effects by an opposing substance. As Cushing says, "Have Alice nibble from a pituitary mushroom in her left hand and a lutein one in her right and presto! she is any height desired." And going further, with doses of

secretion x carefully checked by doses of secretion y she can reach any moral height desired and still be brought down by her anxious family before irreparable harm has been done.

The social worker has begun to study the internal secretions. Will not the minister and the educator follow? There are so many unsatisfied desires coming to the attention of these professions; it is impossible apparently to bring authority to suppress these desires; and so a welcome is ready for relief through chemistry. In goes so much gland sustenance and out comes the difficulty, and there soon will be little for the societies for mental hygiene to do.

The "outgoing wife" can now be made to stay at home under the hibernating influence of the posterior pituitary—that is, if her husband has first chance at the medicine chest. A disturbing thought has entered with the last sentence. Is the wife to be soothed or the husband stimulated? Whose unpleasant characteristics are to be removed? What are unpleasant characteristics anyway? Who shall give John the wherewithal to become a poet and imbue James with a passion for work?

We have not at hand the wisdom to answer these questions, but after us will come those who will have grown to a wisdom we have not seen. The made-to-order man approaches, the made-to-order genius, and, what concerns us more nearly, the made-to-order family. We can surmise that a judicious selection—"man for the first time taking part in his own evolution"—might for the sake of variety allow in some individual of the family a certain trait to become developed fully and unusually, but to be made innocuous by complementary differences in other members of the family group—for every bump a hollow. But as a bumpy individual would be uncomfortable when he left the family circle, it seems likely that it would be less troublesome to have no bumps anywhere. Almost without realizing it we face the possibility of all men becoming well rounded and equal, like a row of ciphers.

An internal secretory Utopia would have enough of everything, but not too much: enough patriotism to carry on for an emergency, but not too much interference in long-continued activities under the flag. Freed from the difficulties of dealing with unmeasured sources of energy, it would have to guard

only its *abattoir* and cold-storage plant to secure itself against diminution of its intellectual and moral forces. Enough Horatii could be produced to hold the bridge and at the precise moment swim back across the floods to inconspicuousness. Looking backward, it is hard to believe that, without the help of modern chemistry, the Romans did so well.

THE PROBLEM OF THE MENTAL MISFIT IN INDUSTRY*

GEORGE K. PRATT, M.D.

Medical Director, Massachusetts Society for Mental Hygiene

WHEN the United States Government called up four million men to fight a common enemy, it called with them almost every legitimate branch of medical science to safeguard their health and to restore them to duty when wounded. Well to the fore of these medical cohorts was a little group, new to military science, looked on askance by some and with derision by others. The Surgeon-General's Office, with becoming dignity, referred to them as the "Neuropsychiatric Division of the Medical Corps", but by almost common agreement the line, more practical, albeit less nice, dubbed them "nut pickers".

Their duty was twofold. The Allies had been badly perplexed and harassed by large numbers of nervous and mental upsets among their troops. Indeed, several divisions holding important sectors had been severely handicapped by the steadily increasing streams of ineffectives going to the rear, wounded, not in body, but in mind. Some of these were frank cases of recognized insanity. These had been anticipated and allowance made for them in estimating battle losses. But there were far greater numbers of a type of disorder generally unrecognized and for want of a better phrase called "shell shock". In 1914-15, military physicians were inclined to think that a new, heretofore unknown mental disorder had been engendered by conditions of modern warfare.

Then here and there a bold psychiatrist began to advance the theory that these "shell-shock" cases bore a remarkable resemblance to certain supposedly rare cases of civilian hysteria and psychoneurosis, and by 1917 this theory had been more or less generally accepted as proven and true. It had

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been discovered that since the soldier of to-day's draft army was the citizen of yesterday, it was not unlikely that the mental upsets of military life would bear a striking similarity to those in a civilian community, especially if allowance were made for differences due to a military coloring of the symptoms. It was further discovered that certain types of men seemed more susceptible to these mental maladies than others, and that the efficiency of the army was better served if these types were either excluded entirely or at least prevented from reaching the battle area.

And so it came about that "shell shock" was found to be civilian hysteria masquerading under military disguise, and, with the stripping away of the veil of mystery that had previously enshrouded it, came a healthier outlook and a more hopeful prospect of combating it with means already known to medical science.

By the time America entered the war, the incalculable advantage of all this information was available for us, and the Neuropsychiatric Department was organized to combat similar conditions among our own troops. It has been stated that their task was twofold: First and foremost they were expected to return to duty in the shortest possible time every possible man who had undergone a mental or nervous breakdown; and secondly they were expected to strike at the root of the whole matter by detecting and excluding from the army —or at least from the fighting zone—those men who hard-won experience had taught were most likely to be mentally overcome by battle conditions.

For the first time in the history of the world a soldier was to be selected for qualities other than a sturdy physique and a strong right arm.

The results of the efforts of the Neuropsychiatric Corps are now well known. Applying to military conditions their knowledge of mental matters born of a civilian experience, these psychiatrists labored indefatigably, in the camps to exclude or adjust, and in the trenches to cure and restore, mental casualties.

Once the novelty of seeing them in uniform and under army conditions had worn off, the psychiatrist began to recognize familiar types. In the camp "goat" or "bone-head", he saw

the defective of civilian life; among certain of the so-called conscientious objectors, he recognized the psychopaths and irreconcilables of the outside social world; in those who habitually fell out of line and complained of short breath, palpitation of the heart, and kindred aches and pains, all based on no discoverable physical findings, he renewed acquaintance with the same neurotics who contributed largely to his civilian practice. All in all, the psychiatrist perhaps felt more at home in the army than any of his professional brethren. It required as little imagination to see the potential "shell-shock" case of the front line in the man who developed an hysterical paralysis of the arm after an anti-typhoid inoculation as it did to connect the dull, stupid camp defective with the later gas casualty, who fumbled and hesitated too long with the fastenings of his mask, or who perhaps jeopardized the lives of his patrol in No Man's Land by not lying "doggo" quickly enough under the white glare of a Very light.

Not all these fellows were discharged outright, however. Sometimes a hard-headed line commander who had not yet seen the light would become vocal in his opposition to wholesale discharges, or again—and more frequently—the labor battalion safely, neatly, and satisfactorily absorbed the willing muscular output of the defective whose cerebrations were too slow and uncertain for front-line fighting, but whose ability to build roads and dig ditches in Georgia or Iowa was not to be sneezed at. This problem of adjustment without discharge soon became a most important one. Not only was it often found possible to use a mental defective satisfactorily in the rougher work about camp, but many a neurotic whose vague, but always constant half-illness made him utterly useless for drilling or machine-gun practice more than earned his keep when given a job as orderly, or in the office, or at a task compatible with his special abilities and disabilities.

Even the despised conscientious objector could often be induced to wield a broom if not a bayonet. And so it went, a large portion of the psychiatrists' time being spent in ceaseless compromise. But it paid. Seventy-two thousand American recruits were rejected entirely from the service for various mental and nervous disorders and defects; fully twice as many mental misfits were placed in jobs suited to their capacities

and rendered useful; and while no definite figures are available, the proportion of severe mental cases that developed in American troops in France is known to be well under similar figures for the French and British forces.

The one great underlying fact brought out by these experiences was that the mental-health problems of the army were essentially the same as those in the civil population, and that the type of individual who was likely to become afflicted was pretty generally the same whether one called him soldier or citizen.

That the mental misfit in the army created a special problem is as undeniable as the fact that he has created a similar problem in the community at large. As a matter of sheer self-defense, both army and society have been compelled to recognize this problem and to devise means for its solution.

To demonstrate that the mental misfit in industry has created a problem is not difficult. To offer a specific solution of that problem is beyond the present-day status of our knowledge.

The student of industrial conditions is quickly impressed by the fact that the problem of the mental misfit in industry, like that of the mental misfit in any other walk of life, has its source in society in general. The worker—that all-inclusive term—is also the soldier, the scholar, and the citizen, and that he may at times be maladjusted in the factory is as much to be expected as that he should be occasionally out of tune in a military environment or in that of the university.

After all, who is this worker, this hypothetical person, referred to in military parlance as "man power", in the words of the political demagogue as "the common people", and in industrial terms as the "force" or the "hands"?

Arthur Pound describes him unusually well in *The Iron Man in Industry*[1]: "He is the fellow who made up the ranks of the army as examined for the draft—an adult male—with an intelligence, by test, of from fourteen to sixteen years. He is a dependable being on the average, capable of taking care of himself and his family in ordinary times and in not too complicated situations; fairly adaptable; amenable to law and

[1] *The Iron Man in Industry*, by Arthur Pound. Boston: The Atlantic Monthly Press, 1922. p. 52.

social usages; requiring and accepting leadership in all pursuits calling for special knowledge or quick decision; fundamentally loyal to his country and its institutions; inherently conservative and provincial; shaking down after the first flush of youth into a steady, plodding citizen, more prone to excitement over little things than to thought over fundamentals; strongly sexed, but controlling his sex calls more or less successfully with the aid of church and state, of which institutions he is ever the pillar and support."

This in general is the type of worker who mans industry. He is neither better nor worse than his prototype in the army, the school system, or the community. Some of him is burdened with mental twists and quirks and some with physical infirmities. Taking him by and large, he represents an average cross section of the American nation.

This composite picture is so apparent that one wonders why industry at times assumes its problem of the mal-placed worker to be peculiar to itself or more vexing than that of the courts or the educational system. And then it is recalled that, relatively speaking, only yesterday did these two latter institutions begin to stir in their lethargic sleep and gradually to discover that they must study these misfits as *individuals* and not as masses or types.

One is inclined to believe that here possibly is the crux of the whole matter. For centuries logicians have assumed that man, the world over, excepting for minor ethnic differences of race, stature, and physical qualifications, was of essentially the same make-up. It was further generally assumed that in a given situation all types of man would react with approximate similarity. To-day much of this medieval attitude can be found still extant and virile in many of our courts and colleges.

Much of our criminal code is based on it, our entire educational system was designed on a slight modification of this theory, and a World War was required to awaken a complacent military to the fact that "man power" in the final analysis was individual, and that no two soldiers responded quite alike to the same stimulus. And while to-day courts, schools, and army have all, to some extent at least, readjusted their mechanism to allow for recognition of the individual and his

character differences, industry has lagged behind. With a few notable exceptions, modern industry appears still to think of its shop personnel in terms of so many "hands" rather than of so many "hands" *plus* minds and nerves and instincts and emotions. No doubt industry, in the interests of increased production, would like to divorce the former from the latter, feeling that minds, nerves, instincts, and emotions are impediments to the proper functioning of a factory that worships at the shrine of Standardization. But, "Take me—take my dog" is Mother Nature's facetious reply to this desire, and whether it will or no, industry is now realizing that with the worker's hands and muscles, it must also accept his likes and dislikes, his prejudices and his passions. The ignoring of this obvious fact is one of the elements that enter into the making of an industrial misfit. In the past decade, tools, materials, shop practice, and machines have been standardized to a high degree. Automatic machinery has more and more supplanted human effort, and all in an attempt to reduce to the minimum even minute variations in the appearance and quality of the finished product. The modern industrial concern has succeeded in subjecting to its indomitable demand for uniformity every item concerned in production but one—the worker. He alone resists fusion in the smelter of homogeneity, and if, during the melting process, his rebellion boils over, then industry has participated in the *accouchement* of another misfit.

One may reasonably assume, then, that if the type of worker manning industry is essentially the same as that which comprises the bulk of the community, he will possess a like susceptibility to those factors that make for mental impairment, allowing for differences in symptoms due to industrial coloring.

The community is here and there dotted with feebleminded-ness. So is industry. The community is handicapped by its constitutional inferiors and its neurotics. So is industry. The community has its rebels against the civil and social codes in its psychopaths and its irreconcilables, while industry finds it necessary to contend with its radicals and agitators. And just as some communities to-day deny the existence of a mental-health problem within their borders, so do some in-

dustrial concerns reject the suggestion that a goodly portion of intramural friction, excess spoilage, high labor turnover, excessive frequency of accidents, and a dozen and one other shop problems whose ultimate expression is to be found in decreased production, decreased dividends, and increased plant costs and insurance, may all have a common source in mentally insanitary conditions within their own confines.

The manager of a large paper mill derided the suggestion that a falling off in production and a seething unrest among the operatives of a certain roll mill might have its origin in the instability of temper and fluctuation of purpose of a newly appointed foreman who was obviously on the edge of a manic-depressive upset.

An automobile factory installed at great expense an elaborate system of automatic safeguards for their machines. Ten months later they were deeply concerned to find that their accident frequency had declined only about half what they had been led to hope. Analysis of the figures, however, showed that while the total number of accidents remained unduly high, they were occurring in a smaller group of employees. In other words, under safeguarded conditions, most of the accidents were occurring in a relatively small group of "repeaters", who were being injured again and again. Several of this group were later found to be definitely feebleminded and a few more to be emotionally unstable and negligent to an unemployable degree. This incident suggests a parallel between the mental mechanisms of the industrial-accident repeater and the court recidivist.

Feeblemindedness in industry is not the wholly unmitigated menace it often appears to be. To be sure, an unrecognized defective may create much misunderstanding and trouble, and the fact that the higher grades especially give little physical hint of their limited intelligence makes their employment easy and their subsequent detection difficult. And yet, properly assigned and in certain jobs, the defective is a satisfactory and even a valuable worker. Indeed, in those industries where automatic machinery largely predominates—such as the automobile and, to some extent, the textile plants—the subnormal individual is often deliberately sought out. Very average manual skill and even less than average intelli-

gence are the easy demands the automatic machine makes of its operator. Mental effort of a minimum amount is required, and the unimaginative, content-with-the-present mind of the defective plods along at his task quite unaware of the deadly monotony that quickly creates aggravated "labor strain" in his more highly endowed brother.

For such jobs the subnormal workman is an almost ideal type. He obeys without questioning; he is content to be led; he indulges in no dangerous "thinking" about his fancied socio-industrial place in the world; and, being essentially a creature of fixed habit, he soon learns the simple operation of his automatic machine and cannot be easily induced to depart from the routine thereof. As witness to the veracity of these assertions, one has only to recall the testimony of divers employment managers, no small percentage of whom also assert that the highly automatized factory actually tends to place a premium on limited intelligence.

Most of the objection to the defective in industry seems to arise only when he is maladjusted. A man of twenty-six with a mental age of ten and a slow reaction time will almost certainly in course of time sustain an injury if operating, say, a high-speed grinder, or perhaps a drill press which demands a measure of fine judgment.

An individual of this type, after careful examination, was discharged from the army as a "mental defective". He was employed, on recommendation of a Federal Vocational Training Board, by an automobile firm as a helper on their loading dock. Admirably fitted for this work, being strong and willing, he soon sank into a comfortable niche and gave eminent satisfaction. Indeed, so well did he and his job fit each other that when an opportunity arose, a well-meaning and patriotically inclined foreman promoted him, on his statement that he could operate an automobile, to a position as truck driver.

The short hauls in the plant yard between assembly department and freight platform were easily negotiated, and for a time all went well. And then one day, during the absence of an older driver, he was sent across the city to pick up a five-ton load of motors and told to "hurry". The return trip necessitated the crossing of a railroad track, and the inevitable happened. A combination of slow reaction time and chronically

defective judgment brought the loaded truck and a fast freight together on the track at the same moment, and in addition to several thousand dollars' worth of damage to truck and motors, the family of the dead boy brought heavy suit.

Properly fitted to a job compatible with his stunted intellect and abilities, a mental defective above the grade of imbecile seldom causes trouble. Misplaced, he is a never-ending menace to himself and all those about him.

Just as in the community we find friction, misunderstanding, and distress ever following in the wake of the psychoneurotic, so do we find similar symptoms in industry. The same mechanisms that serve to translate the mental difficulties and conflicts of the citizen into terms of physical discomfort and ill health operate in like fashion in the workman. Neurasthenia, that type of mental disorder that reinforces or simulates physical invalidism, takes as much toll in the shop as in the home, and its industrial severity is further enhanced by the fact that the foreman recognizes it for what it really is as infrequently as the physician.

Poorly balanced emotional equipments do not stand out in bold relief as do crippled joints or a wooden leg, and when their owners become inefficient or give vent to easily aroused anger or seem constantly irritable, custom is prone to attribute such outbursts to "cussedness" rather than to a little understood "sickness".

Thus the neurotic bank clerk, complaining of constant headaches, of early fatigue, of constipation and irritability, may be subconsciously struggling against dislike for a frivolous wife, hastily married in a moment of sex madness. He is the emotional, if not the blood, brother of the workman whose back habitually aches, whose anger blazes forth on trivial pretext, who is oversensitive and overtired, whose work is often spoiled, and who, underneath all this, may be blindly revolting against a shop life whose only hold is the increased financial gain for his family that a coveted farm existence cannot offer. It matters little what the precise process may be, the outward results are similar, and as the struggle becomes a chronic condition, both bank clerk and workman are likely to become known as "grouches" or "touchy", and the rest of

the crowd begins to edge away. The end results are invariably seen, but seldom the cause.

Industry teems with this unrecognized type. Production and accuracy of work are maintained at fearful expense to the neurotic's ability to repress, and often inefficiency crops out despite frantic struggling. Fatigue of mind brings about inattention and lack of concentration, just as fatigue of mood is marked by a mild depression, a tendency to worry, and lack of enthusiasm or even dislike for persons or things formerly held in high esteem. The creation of imaginary, self-made situations is a peculiarity of this type, and more than one serious injury has been sustained during a moment when attention was distracted from the work in hand to the distorted fields of daydreaming in which the neurotic seeks a comforting, but artificial surcease from conflict.

More spectacular perhaps, certainly more vexatious, and incidentally more difficult of detection, is the industrial psychopath and inferior. While psychiatry has long been more or less familiar with the unreliability, the *penchant* for precipitating trouble, and the habitual dissatisfaction of this type, industry only recently has come to connect his maliciousness and antisocial conduct with certain of its labor agitators and chronic "kickers".

The neighborhood "grouch", perpetually suspicious, litigious-minded, and socially disgruntled, has his counterpart in the grudge-bearing workman—querulous, resentful of authority, and always "in bad" with his fellows.

This chap may be, indeed frequently is, of more than average intelligence, and is often a skilled workman as well. But tenure of position is constantly being threatened by one sort of dissatisfaction or another. This job is too hard for the wages paid; that one is dominated by a disliked foreman; another is with a firm whose welfare personnel is thought too zealous; and so on *ad infinitum*.

In a paper on this subject by Southard, written a short time prior to his death,[1] Jau Don Ball is quoted as offering a list of industrial types that might well come under the designation

1 See *The Movement for a Mental Hygiene of Industry*, by E. E. Southard. MENTAL HYGIENE, Vol. 4, pp. 43-64, January, 1920.

discussed. Among these he enumerates "queer guys, eccentrics, disturbers, querulous persons, unreliable and unstable fellows, misfits, the irritable, the sullen, the socially disgruntled, unsociable, negative, conscientious, litigious, bear-a-grudge, peculiar, glad-hand, gossipy, roving, restless, malicious, lying, swindling, sex pervert, false accuser, abnormal-suggestibility, and mental-twist types".

And while fully agreeing with Ball that "it could not be concluded from this or any other examination that all strikers, whether agitators or not, are psychopaths", one cannot escape the conviction that in the pathologic dissatisfactions, the antisocial activities, and the oftentimes brilliant, but distorted cerebrations of these psychopathic individuals, the seeds of more than one case of shop unrest and labor difficulty are to be found. Stewart Paton calls such manifestations "the defense reactions of inadequates", while Pound believes that such types have a lowered threshold of resistance to "labor strain". Classify them as you will, the fact remains that the industrial psychopath is a thorn in the side of every plant management. No shop is too small to harbor at least one of them, and one who may be especially maladjusted can destroy in a week the entire morale of a plant which it required years of patient efforts to build.

Brief mention may be made of two other types of mental misfits in industry. One consists of a group of employees who develop, on the job, so to speak, certain mental disorders. Most common of these conditions are a developing general paresis, a premature arteriosclerotic process, and an incipient dementia praecox. And while causative factors differ in each case, they all have a common initial symptomatology in change of character. Beware of the old and trusted workman whose shopmates confess to puzzlement because he seems "different". Perhaps, from a quiet, sober, self-respecting demeanor, he begins to grow careless, boisterous, obscene in speech, and forgetful. Or he may depart from lifelong habits of thrift and squander money recklessly. These are but a fraction of the character changes that are the outward, warning expression of a deteriorating organic mental process. It is not only the aged worker suffering from frankly recognized senility that undergoes these disorders. Only too often they

afflict the middle-aged man of from forty to fifty. General paresis is no respecter of persons and little of age; premature arteriosclerosis may appear long before normal senescence is expected; and dementia praecox is, of course, a specter of youth.

The second type of industrial misfit is equally important. In fact, strictly speaking he has no title to the designation "mental" misfit whatsoever, for he is as normal minded as one could wish. And yet he often creates a problem. I refer to the superior type of workman, superior in ability and intellect, who nevertheless is placed in an inferior job and is not promoted. Nothing can be quite so soul-deadening as the situation of the employee with a family, working at a task that consumes only a minor portion of his skill and ability, who, for a hundred and one economic reasons, finds a more advantageous location impossible.

Friction and dissatisfaction as inevitably follow in the wake of this man as they do in that of the inferior worker in the high-grade job. Such a situation rapidly tends to destroy the morale of the superior workman, and as surely as the sun rises, he is sooner or later going to express his dissatisfaction in terms of unrest and resentment. Thus is one kind of agitator born, and an especially menacing one, for being anything but a psychopath or a defective, he diverts his superior intelligence from a job that can use only part of it to stirring up his fellows with the surplus. On the other hand, like all the other types discussed, fit this fellow to a task in keeping with his abilities, promote him when he deserves it, and his mischief-making tendencies dissolve into thin air.

While adhering to the promise of attempting no dogmatic solution of these problems, one is disposed to hope that its broader aspects may be lightened by an extension of the mental-hygiene movement, which has already invaded the community, the courts, and the schools.

Mental hygiene has assisted in the untangling of many a knotty social and legal problem by explaining the "why" of certain conduct or behavior manifestations. In a very practical way, it has been of inestimable value to society in demonstrating, for instance, that many a so-called criminal is a mental misfit in the social code, and again that certain

children who may habitually lie or steal or run away may need, not punishment, but to be understood that they may be restored to a plane of future usefulness.

Mental hygiene opposes the old viewpoint of medicine and the law, which was concerned only with end results, and substitutes therefor a policy of prevention of mental disorder, a scientific policy whose practical success psychiatry has amply demonstrated.

The roots of the problem lie deep in the instinctive life of man—be he soldier, citizen, or workman. That the industrial workman is recruited from the community, and that therefore the problems of industry and of the community are in the final analysis the same, are so obvious as scarcely to warrant comment. And yet until industry as a whole studies the *individual* and his needs and desires, the mental misfit will continue to be a problem.

THE PSYCHIATRIC WORK OF THE NEW YORK PROBATION AND PROTECTIVE ASSOCIATION*

ANNE T. BINGHAM, M.D.

Psychiatrist, New York Probation and Protective Association

THE question is often asked: "Of what use are psychiatric examinations in meeting social problems?" This report, based on 839 mental examinations made from May 1, 1920 to September 30, 1921 is an answer to the above question, according to the experience of the New York Probation and Protective Association, and the conclusions based on these examinations coincide in many details with those that have been accumulating for over ten years. Belief in the necessity for understanding the delinquent as thoroughly as possible and then for individualizing treatment was the corner stone of the mental work of this association, and the superstructure has been consistent with the foundations. Variations have been an extension of this principle to different groups; the principle itself has not varied. During the seventeen months' period covered by this report, work has been carried on with four different groups naturally reached in the development of the interests of this association, which now seeks to prevent delinquency as well as to handle its frank manifestations.

Group 1. 477 girls who were either staying temporarily at Waverley house—the detention home of the New York Probation and Protective Association—or who came there merely for examination. The latter were referred by district workers of this organization or by other social agencies. Practically all of this group were either delinquent or presented conduct problems that indicated a need for preventive work if delinquency were to be avoided.

Group 2. 300 girls and women examined in the Women's Day Court—the younger prostitutes and those charged with incorrigibility.

Group 3. 37 young women employed during the day, for whom evening appointments were made at the Girls' Service Club. Many of these

* This article is a report of the mental work of the New York Probation and Protective Association from May 1, 1920 to September 30, 1921.

patients were nervous and unstable, greatly in need of help in making personal, family, industrial, and social adjustments, but it was not a defective or a delinquent group.

Group 4. 25 pupils in a girls' high school, problems to their advisors because of physical, mental, nervous, scholarship, or behavior difficulties, but not socially delinquent.

Our initial studies of girls consist uniformly of (1) *family and personal histories* which are verified by (2) *investigations* as extensive as is possible or practicable; (3) *physical examinations* to determine general fitness and the presence of remediable abnormal conditions or of infections that may call for isolation as well as for treatment; (4) *mental examinations*, including psychiatric and psychometric tests besides consideration of nervous balance, personality traits, emotional response, and reactions to specific experiences in life; (5) brief reports in which are embodied diagnoses and recommendations for subsequent treatment.

As a means of standardization of our material and for the sake of gaining a rough idea of intelligence, we have employed quite routinely the Terman revision of the Binet test as a part of our mental examinations. We were not dealing with an illiterate group, as all except about 6 per cent had had more than a fourth-grade education (over 31 per cent had gone as far as the eighth grade) and over three-fourths were native born, so that there was little language difficulty to consider in evaluating results.

The following table compares in respect to mental age a group of delinquent women in New York state reformatory institutions[1] with a group of 460 of our girls. Our group does not include the 300 girls and women examined in the Women's Day Court, 54 cases in which for various reasons psychometric tests were not given, or the 25 high-school pupils, who do not belong in the delinquent category.

It is now well known from recent published reports[2] that the mean mental age of the white draft is 13.4, and as a result

1 See *A Study of Women Delinquents in New York State.* By Mabel Ruth Fernald, Mary Holmes Stevens Hayes, and Almena Dawley, with a statistical chapter by Beardsley Ruml and a preface by Katherine Bement Davis. New York: The Century Company, 1920.

2 *Psychological Examining in the United States Army.* Edited by Robert M. Yerkes. *Memoirs of the National Academy of Science,* Vol. 25. Washington: Government Printing Office, 1921, p. 785.

many psychologists are coming to the opinion that average adult intelligence is more properly represented by a mental age of 15 or even 14 rather than 16 years, which was formerly considered the point at which mental growth ceases.

Comparison of Mental Ages of Delinquent Women in New York State Reformatories and Girls Examined at Waverley House Mental Clinic.

	New York Delinquent Women		Mental-Clinic Girls	
Mental Age	Number	Per cent	Number	Per cent
19–20	1	0.2	—	—
18–19	2	0.4	4	0.9
17–18	4	1.0	7	1.5
16–17	10	2.2	17	3.7
15–16	27	6.0	45	9.8
14–15	30	6.7	48	10.4
13–14	47	10.5	59	12.8
12–13	62	13.9	73	15.9
11–12	76	17.0	75	16.3
10–11	89	19.9	58	12.6
9–10	60	13.4	30	6.5
8– 9	30	6.7	31	6.7
7– 8	6	1.3	9	2.0
6– 7	3	0.7	4	0.9
Total	447	100.0	460	100.0

If we interpret the above table in terms employed in the army classification and consider that a mental age above 16 indicates a *superior* type of intelligence, it will be seen that the percentage of "superiors" in our group is somewhat larger than in the reformatory group—6.1 per cent to 3.8 per cent. Regarding the average mental age as lying in the period from 11 to 16, we find that here our group bulks large—65.2 per cent as against 54.1 per cent of the reformatory women. In the *inferior* class, with mental ages from 9 to 11, our group (19.1 per cent) falls below the reformatory women, one-third of whom (33.3 per cent) are found in this class. In the final division of the definitely *feebleminded,* our group and the reformatory group are almost equal—9.6 per cent and 8.7 per cent respectively. The mean mental age for our girls is 12.3 and that for the reformatory cases 11.8.

There is at present a healthy reaction from the tendency, prevalent a few years ago, to attribute to mental defect most

of the ills that infest society. Such an extreme view could not long be maintained. Practical experience disproves it, and such figures as the above indicate that a conservative estimate would place over 50 per cent of our adolescent delinquents in the average class *so far as their mental capacity is concerned.* However, the intelligence or mental capacity of our conduct-problem cases is by no means all that we have to take into account in estimating them. It is possible for a person to have a high intelligence quotient and yet be suffering from mental disease. A good mental development is not uncommonly found in a psychopathic personality. The next table, which gives a general classification based on psychometric and psychiatric findings of the four groups that we have studied, goes a step further than the table that presents merely mental ages, as it takes into consideration to some extent individual differences. It is far from satisfactory, nevertheless, as it does not allow for those individual variations that are dependent on neuropathic constitutions, personality traits, emotional reactions, and the like—factors that are of immense importance when it comes to understanding a person, regardless of intelligence or mental status.

Mental Diagnoses of Cases Examined from May 1, 1920 to September 30, 1921

Diagnosis	Total		Mental Clinic at Waverley House		Court		Evening Conference Hour	Washington Irving High School
	Number	Per Cent	Number	Per Cent	Number	Per Cent		
Normal intelligence	131	15.6	105	22.0	11	3.7	6	9
Dull normal intelligence	117	13.9	84	17.6	22	7.3	1	10
Border-line intelligence	122	14.5	65	13.6	52	17.3	3	2
Mentally defective	196	23.4	123	25.8	71	23.7	2	...
Psychopathic	199	23.7	58	12.2	129	43.0	10	2
Psychoneurotic	26	3.1	18	3.8	...	...	7	1
Psychotic	33	3.9	15	3.1	14	4.7	3	1
Epileptic	10	1.2	8	1.7	...	...	2	...
Glandular case	3	0.4	...	...	...	...	3	...
Drug addict	2	0.2	1	0.2	1	0.3	...	...
Total	839	100.0	477	100.0	300	100.0	37	25

In the preceding table we have ordinarily employed the term "normal" when the intelligence quotient resulting from a Terman test was 90 or above, and when, in addition, a constitutional psychopathic state, a psychosis, epilepsy, or a psychoneurotic condition could be ruled out. In a few instances, where there seemed to be average native ability, but language or educational deficiencies were responsible for low Terman scores, diagnoses of normal mentality were made. In the same way, the terms "dull normal" and "border line" were employed, the former usually when there was an intelligence quotient of from 80 to 90, the latter when the intelligence quotient ranged from 70 to 80. But in some few instances, where the conduct and general attitude warranted it, diagnoses of mental defect were made when intelligence quotients were over 70. Generally, however, the term "mental defect" was used in cases where the intelligence quotient was below 70[1] and the school record and social history indicated inability to manage affairs with ordinary prudence or competence; that is to say, the Terman tests were employed as routinely as possible because, as we have already stated, the value, for purposes of comparison, of well-standardized psychometric tests was recognized. But the result of a Terman test was never the sole basis for a diagnosis, as individual reactions and make-up, also, were invariably considered in deciding the person's mental status.

The "psychopathic" group, as used in our terminology, includes those individuals in whom instability is a prominent and consistent trait. There are, also, frequently found in this group defective emotional reactions to situations, either exaggerated or inadequate, a lack of ethical sense, exaggerated egotism, and, as a result of these conditions, single or combined, poor adaptive power. Such people are weak, incompetent, excitable—often in a high degree—unstable in mood, sometimes with distinct pathologic trends—for example, paranoidal; yet many of these cases, weak and antisocial as their conduct shows them to be, may make a good showing in a Terman test.

The better to describe these individuals, we sometimes subdivided them into constitutional inferiors, constitutional psy-

[1] Excluding deteriorated conditions from psychoses or epilepsy.

chopathic inferiors, and psychopathic personalities, the constitutional inferiors having less instability than the constitutional psychopathic inferiors, the psychopathic personalities having higher intellectual development than the other two, but showing marked instability, egocentricity, and extremely low adaptive power.

Under "psychoneuroses" we included hysterias, feelings of inefficiency, morbid fears, anxiety states, and the like. The terms "psychoses" and "epilepsy" need no explanation.

It was interesting, though not surprising, to find in the high-school group a relatively larger number with normal intelligence than in any other one group—a fact strikingly illustrated in the alertness of these girls, in their interest in studies, reading, sports, music, clubs. Their vivid enthusiasm for a variety of wholesome things was in marked contrast to the paucity of interest in our delinquents, who were resourceless, for example, in providing entertainment for themselves and who depended for their pleasure on the constant external stimulus of dance halls and moving pictures instead of showing ingenuity, initiative, and imagination in devising original recreation. We are often told that one reason why these delinquent girls seek their pleasure on the streets and in public places is because their homes are so unattractive that there is nothing to hold them, but this argument is refuted by the fact that there are many girls in the high school who come from as bare and poor homes as any of our delinquents, yet their interests and ambitions safeguard as well as lend zest to their humdrum, poverty-stricken lives. The part that the better intelligence of this latter group plays in the production of interest in life is, of course, not to be forgotten. It is worthy of note, also, that although these high-school students were referred because they were problems, only two of the 25 girls were considered psychopathic.

As an illustration of the small amount of mental conflict that the behavior of our delinquents occasions them we found that of the court group none were considered psychoneurotic, and only 3.8 per cent of the Waverley House girls. A much larger proportion (7 out of 37) was found among the evening-clinic cases, who came for the most part for the discussion of personal problems.

Although we have always included in our medical histories the presence or absence of neurotic traits—that is, convulsions in early life, excitability, timidity, temper tantrums, nail biting, bed wetting, sleep disturbances, tendency to nausea—during the period covered by this report we paid special attention to these conditions, and we believe that the following table, based on 306 cases with positive neurotic traits, is significant.

Neurotic Traits of 306 Girls Classified According to Mental Diagnosis

Diagnosis	Total	Neurotic Traits					
		One	Two	Three	Four	Five	Six
Normal	57	19	18	10	5	4	1
Dull normal	51	20	18	8	4	1	..
Border line	41	11	7	18	2	2	1
Mentally defective	79	25	23	20	8	2	1
Psychopathic	45	12	24	5	4	..	..
Psychoneurotic	17	6	5	4	1	1	..
Psychotic	8	2	1	3	2	..	..
Epileptic	5	1	4	..	..	..	..
Glandular case	3	1	2	..	..	..	..
Total	306	97	102	68	26	10	3

The above table does not include the girls examined at the Women's Day Court, but corresponding data for this group were compiled by Dr. Augusta Scott.[1] It is noteworthy that the percentage of girls with neurotic traits is the same for the two groups—57 per cent. A comparison of the distribution of neurotic traits is shown in the following summary:

	Waverley House		Women's Day Court	
	Number	Per cent	Number	Per cent
Number having one neurotic trait	97	31.7	73	46.5
Number having two neurotic traits	102	33.3	48	30.6
Number having three neurotic traits	68	22.2	25	15.9
Number having four neurotic traits	26	8.5	8	5.1
Number having five or more neurotic traits	13	4.2	3	1.9
Total number having neurotic traits	306	100.0	157	100.0

1 See *Three Hundred Psychiatric Examinations Made at the Women's Day Court, New York City.* By Augusta Scott. Mental Hygiene, Vol. 6, pp. 343-69, April, 1922.

These neurotic traits are tangible indications of a fundamental instability that seriously interferes with the making of the adaptations that daily life continually demands of everybody. Instability such as this is a big factor in the failure of people with average intelligence to adjust efficiently to circumstances, and we have these ordinarily bright but unstable girls running away from home, perhaps, or indulging in other impulsive acts because of quarrels, morbid sensitiveness, or difficulty in putting forth sustained effort or in maintaining interest in routine matters.

These social manifestations of instability are particularly difficult to cope with successfully when they occur in those with definite defect or in the constitutionally inferior, whose adaptive powers are weak at best and who accordingly react badly to the unfavorable environment in which they so often find themselves.

Of the 125 cases diagnosed as feebleminded in our group, excluding the court series, custodial care was recommended for 52; it was obtained for 10 and commitment for 3 others is pending. Reasons for not attempting to secure it for the remaining 39 for whom it was considered desirable are as follows:

Follow-up work handled by other organizations	17
Family opposition	10
Physical condition necessitating treatment	5
Sent to a reformatory	2
Placed at work in hospitals	2
Sent to a state hospital	1
Family disappeared	1
Court insisted on marriage	1
	39

Of the five girls whose physical condition demanded treatment, three had a venereal disease, one was pregnant, and one had trachoma. The girl sent to a state hospital had a psychosis superimposed upon feeblemindedness.

More than passing mention should be made of the case in which the court insisted on marriage, because of the extraordinary attitude of the magistrate towards an obviously feebleminded, unstable, seventeen-year-old girl who unquestioningly went to live with a stranger whom she met in a

moving-picture house and for whom she submissively prostituted herself until she was well advanced in pregnancy. She then returned to a family that had befriended her and through a visiting nurse was referred to this organization. Two men were arrested, charged with abduction. The following report was sent to the court:

"*Your Honor:*

"I submit herewith a report on M. S. who has received physical and mental examinations at this clinic.

"M. gives a history of neurotic traits, which indicate nervous instability. She has defective vision. The Wassermann test is reported doubtful by the Board of Health. She is about six months pregnant.

"Mentally, she is a low-grade-feebleminded girl, definitely at the mercy of her environment, as her power to plan and reason is of such low order. There is no one responsible for her, her mother, a woman of doubtful reputation, having disappeared several years ago, her father being a city charge because of advanced tuberculosis. The man with whom she lived is obviously unfitted to care for her and would be apt only to exploit her if she were allowed to marry him. In spite of the presence of his two children, his apartment was used nightly for immoral purposes, while M. and another girl were living with him.

"In view of the above facts, M. is considered suitable for commitment to a custodial institution, and the necessary papers have been prepared at the mental-hygiene clinic, Bellevue Hospital. As soon as possible after her confinement, arrangements for her commitment will be made."

The judge expressed appreciation for the "sweet" coöperation of this association and announced that he had given the case an unusual amount of thought, as a result of which he had decided that marriage was the most desirable disposition, in order that the coming child should not be a public charge. This he considered a "practical, sensible" view of the situation, and he added that he hoped that no one would think him sentimental. He was not influenced to change his mind when reminded that the two children of this procurer, the prospective bridegroom, were at that time public charges and that later children who might be born of this union stood good chances of becoming public charges, also. That there might be no slip in the matter of the marriage, the court instructed an officer to accompany the pair immediately to secure the license, and the ceremony was promptly performed. As the family went to live in Coney Island, the case was referred to a Brooklyn organization for follow-up care. At last accounts, this low-grade-feebleminded girl, her husband, his

two children, the new baby, and a man boarder were living in two rooms. The husband had been told that the man boarder should be sent away, but he did not seem to see any necessity for such action.

Limited institutional space and family opposition combine to make it impossible to secure custodial care for all those who need such protection, and as a result such organizations as this are called upon to supervise in the community many mentally defective persons who are clearly socially incompetent. The amount of time and energy that these individuals consume is appalling when one realizes how little constructive work is done for them, or how much might be accomplished if a similar amount of effort were expended on more hopeful material. The following case will illustrate my point:

L. M. was a neurotic, feebleminded girl, aged 16 when referred to our association for protective care by another social agency in February, 1920. We found the home and family background bad, the parents and seven children living in four dark, dirty rooms in a bad neighborhood. The father was lazy and intemperate, the mother weak and ineffectual, two older brothers were drug addicts, the older married sister neglected her husband and children and was considered a prostitute. We were the tenth known social organization to interest itself in this family. At the age of 10, L. had been brought before the Children's Court and sent to a Catholic protectory for a year, as her parents were then charged with improper guardianship, intemperance, and neglect. When nearly 15, she was again in the Children's Court, this time for sending obscene post cards to her school teacher. She was put on probation for one year, during which time she was considered satisfactory. Her attendance at school was irregular, and she left at 15½ when in 6B. She was then employed in various factories where, although her work was "fair", she was unreliable, seldom reporting for more than three or four days a week.

Shortly after she came to our attention, L. created considerable excitement in her neighborhood by telephoning to Bellevue for an ambulance, saying that her father was insane. The ambulance came with three officers, but the surgeon refused to take Mr. M. away. Whereupon L. telephoned to the police station, making the same report, and seven policemen came to the house in response to this call, looking for the alleged insane patient. Meanwhile, L. with her bosom friend watched proceedings from the steps with amusement and interest. It was following this episode that L.'s mother made a charge of incorrigibility against her, but before the girl could be produced in court there was another spectacular scene when she attempted to run away from the officer who sought to arrest her, and when finally caught, she was so violent and disorderly that a patrol wagon was called to convey her to court. Her arrest brought her to Waverley House, as she was remanded for physical and mental examinations.

Her mother then gave information hitherto concealed regarding the girl's vile tongue, late hours, threats to run away, and gossip concerning her going into cellars with men. L. vehemently denied sex experiences, but a physical examination did not confirm her denials. According to the Terman test, she had a mental age of but 9.2 (I.Q. 57) and was diagnosed as feebleminded. In addition, she had marked emotional instability with a history of definite neurotic traits. The court requested that the girl be sent to Hillcrest Farm, and although it was regarded as a doubtful experiment, this was done, and for three months L. ceased being a social problem, as she was amenable and "good", at least negatively. On her return to New York, there was some difficulty in getting her placed at work, but after a month she consented to take a position as helper in Campbell Cottage, White Plains. She was reported as shiftless and irresponsible, but not troublesome in conduct. However, after two months she left, saying that she was homesick in the country. She had a "wild" month in the city, running about until all hours with her sister and men in taxicabs and skillfully eluding workers who attempted to convey her by the hand to positions. At last she agreed to become a helper with housework in a small family, and there for a time, under strict supervision, she proved such a success that everybody was pleased, and her mother came to express thanks to the association for the great improvement in L. and, at the same time, to ask if something could not be done for her prostitute daughter.

Before long, however, there were complaints of L.'s undesirable companions, very late hours, and stubborn refusal to improve her ways, so that her employer decided that a "change would do L. good". This was in August, 1921, since which time nothing of benefit has been accomplished for the girl, in spite of much effort on the part of workers. She keeps very late hours, does no work, and insists on going about with her married sister, in spite of the protestations of her mother and of visitors from this association. She eludes the latter, who are commonly greeted by a voice behind a locked door announcing that nobody is home. It is reasonable to assume that it will not be long before L. is a more serious social problem[1]; yet without the coöperation of the family, which it had been impossible to secure to date, commitment to a custodial institution could not have been accomplished.

Some idea of the amount of time consumed in completely unproductive work in this case may be gleaned from the fact

[1] This prophecy was fulfilled in December, 1921, when L.'s mother came to ask for help in getting the girl "put away", as she had recently found her and her sister hiding in the bedroom of an apartment above, occupied by a bachelor. He and another man were present when the mother entered. L.'s late hours and bold behavior with men in hallways had made it necessary for the family to move from their previous home, and it was thought that for the same reason another move would be requested. L. was arrested, charged with incorrigibility, and taken to the Women's Day Court. Although it was hoped that this might serve as a means of securing custodial care, the girl was sent to the House of the Good Shepherd on an indeterminate sentence. A full report was immediately sent to this institution, emphasizing our conviction that the girl should not be returned to the community because of her mental irresponsibility and nervous instability.

that forty-five visits were made, twenty-one interviews took place at club houses or at our central office, twelve letters were written, there were telephone calls, and the placement secretary gave time to securing for this girl two excellent positions, besides referring her to others which she never took the trouble to follow up. The court procedures, also, have all taken much time. Moreover, L. has been altogether forty-three days in Waverley House and three months at the farm, during which periods she was fed, otherwise cared for, and taught. Her reaction to favorable environments is such, for short periods at least, that it is possible she would make a good adaptation to a custodial institution. At any rate, this would seem the only logical disposition of her, as it is clear beyond question that home supervision is a failure in her case, as in that of many others like her.

The deleterious influence of family and companions often greatly overbalances the efforts of a worker to inculcate habits of industry and better personal standards in these mentally defective individuals. Their low critical sense and high suggestibility make them very dependent on their surroundings, and it is often felt that if they could be taken from their homes and have a favorable environment, they might be useful and happy in a modified community life. To meet this need of high-grade cases who are capable of being efficient workers along certain lines, an extension of the colony plan is suggested—that is, placing together, in or near their home cities, under the direction of intelligent matrons, groups small enough to make careful supervision possible. The girls should be placed at work for which they are suited or for which they have been trained and in which they are not subjected to competition with their mental superiors. They should be encouraged to feel financially independent and also to contribute to their families if necessary. This plan would tend to make families more willing to have their daughters away from home than they often are when possessed by the thought of all that the state is realizing from these girls, whose economic value increases with absence. Also, frequent visits, which are often impossible to the more distant state institutions, would serve to allay suspicion.

The supervision that is given in a well conducted colony,

together with considerable liberty, make a good combination for these cases. Recreation, such as other girls have, helps to keep them contented, but it can be kept within safe limits. There is, of course, bound to be a certain amount of failure in such a scheme. This is to be expected, in view of the material involved. But some cases would respond favorably, as the Rome[1] and Waverley statistics show, and the chances for success are better in well conducted colonies than in community life under the care of a parole officer. With the tendency on the part of custodial institutions to parole after a few years adolescents and young adults at the height of their sex life, commitment, which is accomplished with so much difficulty, often seems a farce. While it is undoubtedly true that high-grade defective persons can profit from institutional training in habits of industry, cleanliness, and the like, their instinctive demands are not trained out of them so easily, and girls and young women who have had sex experiences are apt to return to sexual irregularity unless so carefully safeguarded that they have a good substitute for custodial care. In addition to furnishing this, the colony plan, if extended, would centralize the work of community supervision for mentally defective persons and thus free many social workers from the futile expenditure of time and energy that we have concretely illustrated.

By comparing among our cases series of feebleminded girls who have done well with others who have done ill, an attempt was made to find some consistent factor that would shed light on the causation of conduct and thus aid in efficient treatment for similar cases in the future. This study, however, led us nowhere; that is, we found in both groups—those "doing well" and those "doing badly"—girls with comparable degrees of mental defect, with and without neurotic traits; so it is not alone the combination of instability and mental defect that makes for unsatisfactory conduct, important as these factors often are in antisocial behavior.

We come back, then, to our starting point—in other words, to the *absolute necessity* for individualizing the study and treatment of all sorts of problem cases. It is this basis that

1 See *Colony and Extra-institutional Care for the Feebleminded.* By Charles E. Bernstein. MENTAL HYGIENE, Vol. 4, pp. 1–28, January, 1920.

makes the work perennially interesting because of the endless varieties and combinations of personality, emotional reactions, physical and mental conditions, environment, and heredity that underlie human conduct.

Let us consider briefly some cases in which our study has had an important bearing in immediate disposition or subsequent treatment.

W. A., a woman of 24, came one day to Waverley House with her husband and an attorney whom the former had consulted with the idea of securing a divorce. The lawyer suspected from the woman's erotic behavior in his office that she was mentally unbalanced, but did not know how to secure proper care for her and went with the pair to the Second District Court. There the presiding magistrate said that he would seek for advice from a psychiatrist before committing her to Bellevue, and accordingly sent her to Waverley House. The husband stated that they had been married for over four years and had one child. They were fairly happy until recently when his wife offended his sense of propriety by her familiarity, not only with strange men, but with those socially inferior to her. She lost interest in her home, neglected her baby, was very restless, and complained of insomnia. "She had tantrums, when she became violent and cursed." The husband was not impressed by her need for special care, but considered her a wicked woman, and her two attempts at self-destruction, as well as one attack on him, did not serve to give him insight. A very brief examination at Waverley House showed that the woman was definitely psychotic, and she was promptly returned to court with the recommendation that she be sent to the psychopathic ward at Bellevue. This was done and she was transferred thence to the Central Islip State Hospital with the diagnosis of manic-depressive insanity, manic phase. A serious injustice would have been done this patient had she received no psychiatric examination. A recent report from the hospital states that she is improving, and she will undoubtedly take her place in her home as soon as recovery is complete.

P. A., an Austrian girl of 19 living in a neighboring state, was referred by the protective department for an "efficiency test" and came to Waverley House accompanied by her father. This girl, who is seclusive, prudish, a daydreamer, has been out of sympathy and contact with her family since her childhood. She constantly showed great resentment at any attempt to make her act contrary to her desires. She has been restless and has run away a number of times. One of the ambitions that she expresses is to be an actress or dancer, and she once ran away and joined a traveling show. Her family are apparently intelligent and in fairly good circumstances, but they have had no insight regarding the girl's behavior. A short time before her examination, she had come to New York announcing that she intended to stay here, and her father, after talking with the director of the protective bureau, was only too willing to leave her in the city under the nominal charge of this association, since she had been such a problem to her family. Examination showed, however, that she had many of the symptoms of early dementia praecox. She had definite hallucinations, distinct ideas of reference,

and was probably delusional in addition, thinking, for example, that her food was sometimes tampered with for the purpose of poisoning her. It was felt, not only that she should not be encouraged to stay in New York to enter upon the sort of career that she constantly talked about, but that she was distinctly in need of care, either in a hospital or under some psychiatric clinic. The facts were set very frankly before the father and an effort was made to get him in touch with the proper facilities in the state where he lived, but he was unwilling to consider this at the time of our interview, since he feared that such care would make it impossible for her to get work later, and he could not believe that her condition was as serious as it appeared to be. He did, however, take her home. Had no examination been made in this case and the girl been left to an independent existence in New York, she might well have got into serious difficulties, since she was so negativistic that advice presented in the most friendly way was resented.

Intensive study in the case of G. L. materially helped, we believe, to avert a severe sentence which would have been disastrous to a girl of this type. G. is a girl of 19 who was referred by Judge Koenig, of the Court of General Sessions, for fifteen days' observation at Waverley House. She had pleaded guilty to a charge of grand larceny preferred by the department store that employed her, and sentence was postponed for two weeks in order to have physical and mental examinations made. It was thought that G.'s emotional reaction to the serious charge made against her was inadequate. We found that in the matter of intelligence development she was dull. In addition to that, she was definitely immature. This attitude was undoubtedly the result of the way in which she had been brought up, as no initiative or independence of thought or action had been encouraged. It seemed probable that she was an illegitimate child, born when her mother was but fifteen. During her early childhood, G. was passed around from one cheap boarding place to another and never knew any real happiness. When she was 11, she was taken by a maternal aunt and her husband, well-meaning, kindly people, but very narrow and oblivious to the fact that adolescents need a certain amount of recreation and not constant criticism and correction. G. was always timid, sensitive to ridicule, and emotionally unstable. In disposition she was naturally social, generous, and rather pathetically anxious to be liked. She often had dreams that appeared to be simply wish-fulfillments, such as that she had lots of money which she spent for the benefit of others. The atmosphere in her aunt's home exerted a distinct repressive influence, but she made little effort to emancipate herself from the restrictions imposed by her aunt and uncle until late in 1920, when, following an "argument", she went impulsively to spend the night with a married friend. She met kindness and sympathy there, and decided to remain for a while. At home she had not been allowed to make even trivial decisions for herself, and therefore was unprepared to use wisely her suddenly assumed independence. For the first time in her life she bought her own clothes and was forced to use a part-payment plan that reduced her weekly wages embarrassingly. She found in her new environment many opportunities to gratify her liking for giving presents as well as for making herself popular and of some importance. Furthermore, she was free from the searching questions that her aunt had asked regarding any new possessions. At home she had had nothing but actual necessities

in the way of clothes and she had vainly longed for pretty dresses and trinkets. In the large department store where she worked in the jewelry section she was surrounded by a bewildering quantity of beautiful things, and any scruples that she had at first about taking articles seem to have been undermined by a rather easy attitude that her associates had regarding stock.

It was a gradual and insidious process that led from the mere wearing of articles that had been pronounced unsalable or from appropriating pearl beads left after restringing to taking deliberately, to giving away at first things of little value, but later jewelry worth hundreds of dollars.

G. was markedly suggestible and immature; consequently, in situations calling for judgment and foresight she got on poorly. She had not been encouraged to do independent thinking, and this was one reason why she accepted so easily conditions that a more aggressive or a more intelligent person would have rejected. Her emotional reactions were childish. She had capacity for affection and loyalty to friends, but did not grasp adequately the significance and far-reaching consequences of conduct as would an older person or one who had greater mental capacity. Hence her baffling reaction to the charge against her and its possible results.

Because of the girl's personality, cramped and repressed life, nervous instability, and mediocre mental equipment, it was felt that it would be a very serious mistake to give her a severe sentence, which seemed at one time inevitable. We strongly recommended a suspended sentence, and judgment was postponed, with the understanding that G. should be sent to Hillcrest Farm. This plan was immediately put into execution, and G. spent about six months in the country. There she was industrious, generous, and dependable, showing no deceitful tendencies. At first she was quiet and diffident, seldom expressing an opinion, but later she became more assertive and more self-confident, responding favorably to an atmosphere of friendliness, trust, and freedom. She took the greatest delight in everything beautiful. She was thought to be introspective and occasionally spoke of a feeling that there was some mystery concerning her life which had kept from her the affection for which she had always longed.

This extended period of observation at the Farm has served to confirm the impression gained of her during the period of observation at Waverley House. She has good habits of industry, but is not fitted for highly specialized or complicated work calling for rapid readjustments. Telephone operating, which she liked and in which she had made a satisfactory record, is considered a good type of employment for her; she had expected to be given a switchboard in the department store when she was taken on there. It is believed that if she can be given a suitable form of employment and the right sort of home background and companionship, she will become a good citizen.

In the Waverley House group there were many runaways. A special report, *A Study of One Hundred and Fifty Runaways,* was prepared by Miss Elizabeth Greene, psychologist of this association, and read at the Second International Congress of Eugenics, held in New York in September, 1921. The

motivating factors in these cases are many and varied, but looming large by virtue of frequent repetition are restlessness and dissatisfaction, so common in adolescents, as well as curiosity, self-assertiveness, revolt against authority, and a desire for emancipation from family rules or demands. It is an interesting fact, too, that some of these runaways came from families that have a definite tendency to wander. Many are the children of immigrants; they have no love or reverence for this country or for that of their parents. Practically no community ties exist for them, and energy, impulsiveness, intolerance for existing conditions, or a desire for adventure prompts them to leave home. In addition to the instability that is a recognized characteristic of normal adolescents, one finds repeatedly in this runaway group the presence of neurotic traits that point to a neuropathic constitution. The adjustments necessary in dealing with these youthful runaways are often complicated and the results are incalculable. Important factors in treatment are securing a better understanding between children and parents, increasing mutual responsibility, providing congenial work suited to individual capacity, and making satisfactory arrangements regarding the girls' earnings, as well as provision for suitable recreation. In the cases of girls who are returned to their homes outside of New York, efforts are made to carry on through local social agencies the program that develops from our study.

Our experience has shown that for the adolescent girl who lives in New York, or who stays here long enough for some hold to be obtained over her, the treatment that will best stand the test of years consists of the establishment of a friendly relationship between the girl and some worker who thoroughly understands. This does not mean that in every instance where such a relationship exists, one can report that the girl is "doing well"—there are too many unmodifiable or unpredictable factors in such cases to make it possible for any counteracting agent to win out invariably—but it does mean that it is the most constant element in our successes. In the beginning especially, it may be necessary for this friendly interest to extend, not only to all the minutiæ that affect the girl's life directly, but also to everything that enters into her

background. The latter may be practically unalterable, but knowledge concerning it will help materially in understanding the girl and her reactions. This interest cannot stop with such objective things as providing suitable work, arranging for membership in a social club, or securing much needed glasses, important as these things are. It must include also interest in more subtle things, such as home irritations or worries, friendships, love affairs, special reasons for sensitiveness, and the like.

Furthermore, this interest, if it be successful, can be neither simulated or mechanical, for girls are quick to detect perfunctory attention and may resent having the term friend used by one who impresses them as lacking in the attributes of genuine friendliness. Once a girl gets the feeling that she can count on a constant interest, close oversight may not be necessary, as she will want to come and talk over her joys and sorrows with her friend, but it is often necessary to work patiently and warily for the establishment of this relationship in the beginning.

Patients at the Evening Clinic

The small group examined at the evening clinic, most of whom were referred by district workers of this association, presented a variety of problems that involved adjustment to family situations and to personal sex difficulties. There were also cases of improper glandular functioning which produced tension and irritability as well as definite physical symptoms; there were cases of epilepsy, of mild depression, of feelings of inefficiency, and of unhappiness due to various complexes. A lack of understanding of sex impulses was common among these patients, as was strikingly illustrated in the case of an attractive, wholesome-appearing young woman who came with complaints of depression and emotional instability. Although she had received but a limited education, she had, by means of good native ability, ambition, and energy, worked herself up to a position as head of a department, with one hundred girls under her. All went well until she fell in love with one of her employers, marriage with whom, her reason told her, was impossible, as differences of race and social position presented formidable barriers. So keenly anxious was she, however, to have him think well of her that she reacted in a very

morbid and exaggerated way to groundless gossip about her which she insisted was circulating in the office. Because her employer did not immediately dismiss this gossip as ridiculous and impossible, she was hurt, tended to brood, and finally became so obsessed with the thought that she must *prove* her innocence to him that she resorted to most ill-advised methods, wholly out of keeping with her natural good common sense. She realized that she was becoming inefficient and that her position was jeopardized, but she had no insight regarding the underlying mechanism. She was brought to understand this, as well as something of her emotional life and instinctive needs, but her readjustment was slow and difficult.

Another young married woman was a psychoneurotic with syphiliphobia, or morbid dread of syphilis. She was a school teacher with a good educational background and considerable intelligence, but she had not been able to manage her emotional life successfully and showed serious judgment defects. A negative Wassermann served to reassure her regarding her fear of venereal infection, and a chance to discuss her numerous doubts and worries was, she felt, of definite help.

Some of these patients were seen on several different occasions, others only once, but in all cases suggestions for further contact were made to the workers interested in them. From the standpoint of mental hygiene, it is of great importance to get these patients to talk over their difficulties with a psychiatrist. Many are repressed, and the mere breaking down of reserve that a frank talk entails has distinct value. Hardly one of the patients seen at this evening conference hour would have gone to a mental or nerve clinic, as they would either not have recognized their need or they would have shrunk from incurring any possible stigma that might have come from being associated with a clinic of that nature. The Service Club furnished a pleasant neutral meeting place, and the girls had no hesitation in going there to talk over their troubles with a woman physician.

The High-School Group

The longer one works with girls who are usually considered delinquent, the more one is apt to long for opportunities to do preventive work. Therefore, it was with enthusiasm that we responded to the call from the advisors to students at a girls'

high school for help with some of their problem cases, for we realized that here was an opportunity to study the pre-delinquent, or those who showed tendencies towards antisocial conduct, as well as to help in the adaptation of the nervous, the psychopathic, or the dull girl who was attempting work too difficult for her. Two half-days a week were given to this work, from March through June, 1921, and twenty-five girls were seen. In order to gain an idea of what constituted problem cases in a high school, no cases presented as such were refused examination, and the results were most interesting. Roughly speaking, girls were examined because of conduct disorders, poor work, and symptoms of physical and nervous or mental difficulties, these singly or in various combinations.

Among the disciplinary cases was a fifteen-year-old girl, of border-line intelligence, who was incapable of doing the work she was trying to carry. Accordingly, she was bored, restless, and lawless. Recommendation was made that she be changed from the commercial to a trade course, which was more consistent with her limitations.

Another girl of fourteen years, reported for misbehavior in class and a tendency to criticize her marks, had average intelligence, but showed a distinct paranoid trend. She was a spoiled-child type, accustomed to gain her ends at home by tantrums. In school, when corrected, she substituted sulking or lawless talking for tantrums. She was egocentric, willful, opinionated, domineering, and stubborn, and had few friends because it was hard for her to adapt to their ways—"If they don't do what I say, I get angry." She tended to be constantly on the defensive in her remarks regarding school and showed a well-defined grudge attitude. "The bookkeeping teacher did not mark me right. I should have had at least a passing mark, but I got forty or fifty. In Spanish I was nearly the best in the class, but I got only sixty and I should have had eighty. It was just on account of my conduct; I used to scream out the answers. The elocution teacher never called on me, but she failed me. The physical-training teacher failed me because I would not wear gymnasium shoes. They have pets, those teachers."

In the management of this girl, besides certain suggestions regarding physical welfare, it was recommended that she be

given an active share in student government in order to force her to feel more pride in her behavior. This method has proved successful, and a definite improvement in conduct is reported.

Among those referred for physical reasons were five markedly under size, four of whom were sent to appropriate clinics—endocrine, orthopedic, etc. The fifth, Elena, was an Italian girl, aged fourteen, the oldest of ten children, five of whom died in infancy. She lived with her parents and four other children in two small, dark rooms on the lower East Side. To eke out the small earnings of the father, a common laborer, the mother did sewing at home and Elena sometimes helped her, as well as looked after the younger children. She seemed never to have had any childhood herself and was a pathetic, solemn little creature, pale, stunted, undernourished, with defective vision. Her mental development was normal for her age and she did fairly well in her studies, but constantly worried over not being a wage earner.

Immediately after our examination, the student advisors arranged that for a time five dollars a week from a students' loan fund should be spent for this child's benefit. Glasses and dental care were promptly procured. She was given a hearty, warm lunch at school and two glasses of milk during the session. Arrangements were made to give her some recreation and to send her to the country in the summer. She responded immediately by gaining in weight as well as by looking happier and less strained. She passed in all subjects in June, and is now taking a commercial instead of a general course, which will enable her the sooner to become self-supporting.

Caroline, a girl of 17, in the seventh term, puzzled her teachers and advisors by persistent cutting in certain classes and subsequent failure in work. The problem involved her mental status and make-up, as well as whether she should be advised to follow her expressed desire to study pharmacy after graduating from high school. Caroline was a quiet, well-mannered girl, very evidently self-conscious and repressed. Both parents were excitable and subject to marked variations of mood. Her father, a pharmacist, had had a definite nervous breakdown, when he was sufficiently depressed to threaten suicide. All her maternal relatives were nervous and apprehensive. Caroline herself had always been nervous, shy, sensitive, and conscious of an inferiority feeling. She had a violent temper and was often moody. She had been ambitious for a high-school education and did very well until the end of her second year. She then began cutting classes in subjects in which she was not to take

Regents and spent her time on chemistry and history, which interest her. Reasons for later and more extensive cutting appeared to rest largely on sensitiveness and her inferiority complex. For example, she greatly exaggerated a slight lameness and was self-conscious in physical training, which she greatly disliked, as she felt that she did less well than her companions. In French her feelings were sometimes hurt by "sarcastic" remarks of the teacher. So she childishly avoided possible opportunities for unhappiness until her teachers and family made her realize that she must reform or leave school. She had good mental capacity and seemed to react favorably to this ultimatum. She did not cut once during the term after her examination in March and passed all subjects in June with ratings from sixty to sixty-nine. Her desire to take up pharmacy seemed genuine, and it was recommended that she be encouraged to do so if she continued to do well.

The following is the most spectacular case in the small group of high-school girls:

Jean was referred because of what was considered a speech defect, as she either made futile attempts to talk, did not speak loudly enough to make herself heard in class work, or sometimes refused to have anything at all to say. She proved on examination to be a very definitely developed case of dementia praecox, a condition that had been absolutely unsuspected by her teachers and advisors, some of whom had considered that she might be a mental defective. In truth, she had very good mental development, but she was living so completely in a world of phantasy that she did not adapt herself with any uniformity to the demands of home or school. She asked only to be left alone that she might be free to indulge in her daydreaming, but she did fairly in the manual work connected with her dressmaking course. She was referred back to a psychiatric clinic which had lost track of her, and the school, after gaining an understanding of her condition, was willing to have her remain as long as she was able to do any work. Her program was adjusted to her needs.

A fifteen-year-old dwarf, with an abnormally large head, a crooked back, and deformed legs, was referred for physical examination and also because her physical-training teacher reported her as evasive, sly, secretive. This girl described herself as the "cross of the family" and constantly compared herself with a younger sister who was "well built and beautiful". She had never been as sensitive over her physical condition as she has been since coming to high school, as the preliminary school was in her own neighborhood where everybody knew her, and she accordingly did not realize how conspicuous she was until she came among strangers. During her first term in high school she was "blue" most of the time, ate little, and made no attempt to make friends. It seemed likely that her behavior, which was characterized as sly and secretive and which consisted in trying to get off the line in gymnasium, hiding behind the board, and the like, could be attributed wholly to painful self-consciousness, and her efforts not to become conspicuous rendered her more so. She talked freely of her sensitiveness and inferiority feeling so that it was easy to reassure and encourage her, as well as to help her to see how her conduct appeared to others. An

understanding of her personality was helpful to her teachers, and she seems now to be making a much more efficient and a far happier adaptation. She has average mental development and has a good chance for making good in her ambition to become a teacher of sewing for little children.

In all the high-school work splendid coöperation on the part of the principal, the student advisors, and the teachers was unfailingly given, and the prompt and intelligent execution of suggestions was most pleasant and profitable. Discrimination, too, was used in the choice of cases. This group, though small, showed so much variety that the need for psychiatric work in high schools is clearly demonstrated and we are glad to be able to continue it.

Detailed statistical tables[1] will be found at the end of this report (pages 566–74). From these we learn that 265, or about 50 per cent, of our group were sixteen or seventeen years of age. The 33 between thirteen and sixteen were either high-school girls or runaways, some of whom during the first interview found it as easy to add several years to their ages as to "kill off" their families, root and branch, the latter a transparent device for avoiding investigation. Those twenty or over were largely the evening-clinic patients, or cases referred by the courts. One of these was a woman sent for mental examination from a municipal court. She had been arrested for vagrancy, as she had no means of support and various charitable organizations felt that they were not justified in continuing to give her relief, since she refused all types of "menial" work and was not qualified to do anything more in keeping with her ambitions. She gave her age as sixty-five, which was considered a conservative estimate. She was clearly psychotic and was sent promptly to a state hospital for mental disease.

Regarding nativity, we find that while 78.7 per cent of the girls were native born, but 27.3 per cent had both parents born in this country. This is a fact of great importance in family life and in the behavior of these adolescent American girls, whose desire for independence frequently conflicts with the ideas of their parents, many of whom vainly attempt to

1 These tables were prepared by Miss Elizabeth Greene, psychologist of the New York Probation and Protective Association.

impose upon their children the conditions under which they themselves were reared abroad.

Our statistics tell us, further, that the proportion of "unfavorable" to "favorable" environments was approximately two to one, or, in other words, that 64 per cent of these girls were subjected to such unfavorable living conditions as extreme poverty with attendant crowding, broken homes, immorality, alcoholism or crime on the part of members of the family, cruelty or intolerance of parents, or we find that institutional experience played a part in the development of the child or youth. It is hardly necessary to state that, particularly for the suggestible mentally defective or nervously unstable individual, an unfavorable environment such as those mentioned is a factor of incalculable importance in determining conduct.

Although the table on institutional care deals mainly with small numbers, it strongly suggests that advantage is not taken of the opportunity that an institution affords to study different mental types and to base subsequent treatment on the results of such study. We find, for example, that of 119 who had been in at least one institution, 42 were mentally defective, and of these 20 had been in orphanages, 14 in reformatories, 4 in maternity homes, 2 in hospitals for mental disease, and only 2 in custodial institutions.

From the standpoint of education, our group does not make a brilliant showing. Only 45.5 per cent had completed the eighth grade, while but 14.2 per cent had had any high-school work. Nine per cent had attended a trade or business school. Twenty-one of the 25 designated as "miscellaneous" had gone to school only in Europe, and the other 4 were equally hard to classify according to our public-school standards. The 25 students comprising the high-school group are omitted, as their education was not completed at the time of examination.

The prevailing type of work is consistent with the educational attainments of our group. Thirty-six per cent were employed in factories, while 19.9 per cent had domestic positions. Those with better intelligence are naturally found in clerical or mercantile jobs. They show less scattering than do the duller or more unstable.

The wages received varied from less than $8 per week to $30 and over. Two hundred and thirty-three of our group of 539 earned less than $16 a week. It will be noted that of the 123 whose wages ranged from $16 to over $30, 63 fell into the normal and dull-normal groups.

The agencies that found these girls problematical and, therefore, referred them, were actually quite varied, but may be roughly grouped as social organizations, courts, schools, and the police department, especially the Bureau of Missing Persons.

Only 108, or 20 per cent, of our group were considered nondelinquent. Besides the 25 high-school students, these nondelinquents included 24 who came to the evening clinic largely for advice regarding personal problems and 59 others, most of whom were sent for examination because of personality difficulties or because they were making poor adaptations at home or at work. Some were sent because their physical condition seemed largely at fault, but even though this was given as the main reason for referring the girl to us, we made as complete a study as possible, since we realize how difficult it is to evaluate symptoms properly without all available data concerning the hereditary, social, physical, and mental factors in the case.

Four hundred and twenty-eight of the 539, or 79.4 per cent, were considered delinquent. Over two-fifths of the latter were runaways, and it may be of interest to note that 23.8 per cent of these restless adolescents had normal mentality, that 21.2 per cent were considered dull normal, and 10.1 per cent were psychopathic and consequently low in adaptive power and stability. Only 20.6 per cent were diagnosed as mental defectives. One-fourth of the total delinquent group were frankly sex offenders, 17.9 per cent of whom were classified as normal in intelligence, 15.1 per cent as dull normal, and 15.1 per cent as psychopathic, while 32.1 per cent were mentally defective. Besides the runaways and those charged with specific sex offenses, there were still smaller groups with such charges against them as incorrigibility, waywardness, vagrancy, larceny, and so forth. The caption "miscellaneous offenses" included the following: 11 preg-

nant; 3 disorderly conduct; 1 bigamy; 2 alcoholism; 2 homeless; 1 drugs.

Regarding physical condition, it may be said that on the whole it was good; the table on this subject is omitted because it was not considered of any particular positive value. The main conditions demanding attention were carious teeth with diseased gums, unhealthy tonsils, and defective vision. It was estimated that disturbances of the glands of internal secretion existed in 10 per cent of the cases, but this is not to be considered an accurate estimate, as the examiner is not an endocrinologist. Positive evidences of venereal disease was found in but 9 per cent.

The table dealing with mental conditions has already been discussed, but we cannot resist saying, in connection with remarks on our statistical findings, that although we appreciate the valuable background that general social facts supply, the part of our study immediately and fundamentally useful to us in dealing with our cases day by day is that which affords differentiation, but which is not easy to tabulate—in other words, that which acquaints us, not only with the mental status, but with individual traits and temperaments, qualities that cause one girl to react to a situation quite differently from another girl who is her statistical double.

Conclusions

The preparation of an annual report is in the nature of stock taking and should lead to some definite conclusions that strengthen opinions previously held or point to new ideas, the value of which is to be confirmed or disproved. A review of the mental work of the past year, linked to that of previous years, leads us to the following somewhat unrelated conclusions:

I. Our method of study and of individualized treatment is fundamentally sound. Its flexibility has been tested by the different groups with which this report deals.

II. For extra-institutional cases the most effective treatment lies in the establishment of a comprehensive, friendly relationship between the girl and some worker.

III. The difficulty of securing custodial care for high-grade mentally defective persons, owing to inadequate accommodations and lack of parental coöperation, also the waste of the time and energy of social workers in trying to supervise these cases in the community, lead us to advocate an extension of the colony system.

IV. A psychiatric clinic should be a permanent department of the Women's Day Court, not only for the sake of weeding out committable cases of mental defect, epilepsy, and mental disease, but also to aid in constructive work with girls mentally capable of benefiting from probation, by furnishing some clue to personality and to mental mechanisms.

V. Psychiatry has a very real contribution to make to educational institutions. While it is undoubtedly advantageous to detect and treat as early as possible actual or potential mental and nervous cases, it is a fact that at the present time, since little psychiatric work has been done in any schools, the high schools, with their adolescent groups, present material rich in possibilities for the mental hygienist.

Table 1—Chronological Ages of Girls, Classified According to Mental Diagnosis

Chronological Age	Total		Normal	Dull Normal	Border Line	Mentally Defective	Psychopathic	Psychoneurotic	Psychotic	Epileptic	Glandular Case	Drug Addict
	Number	Per Cent										
13 years	3	0.6	3	...	...	...	...	...	...	...	...	...
14 years	12	2.2	5	4	...	2	...	...	1	...	...	...
15 years	18	3.3	6	7	2	3	...	...	...	...	...	...
16 years	133	24.7	32	29	23	29	14	3	1	2	...	...
17 years	132	24.5	28	19	26	30	17	8	...	3	1	...
18 years	83	15.4	24	14	8	15	14	4	2	2	...	...
19 years	49	9.1	8	9	3	18	7	2	1	...	1	...
20 years	33	6.1	6	7	1	8	6	3	...	2	...	...
21 years	19	3.5	3	4	1	5	3	1	1	1	...	...
22 years	16	3.0	1	2	2	4	5	1	1	...	...	...
23 years	12	2.2	1	...	3	3	1	2	1	...	1	...
24 years	10	1.9	1	...	1	6	...	...	2	...	...	...
25 years or over	18	3.3	2	...	...	2	3	2	8	...	...	1
Unascertained	1	0.2	...	...	...	...	...	...	1	...	...	...
Total	539	100.0	120	95	70	125	70	26	19	10	3	1

Table 2—Nativity of Girls and of Their Parents

Nativity	Girls	One Parent	Both Parents
United States	424	55	147
Austria	12	15	32
Belgium	...	2	...
British Isles	16	33	40
Canada	5	9	8
Denmark	1	2	...
France	2	7	2
Germany	5	20	24
Greece	1	1	1
Hungary	5	3	8
Italy	15	7	57
Panama	2	...	1
Poland	4	2	14
Roumania	3	3	5
Russia	25	8	62
Sweden	1	...	3
Switzerland	2	3	1
West Indies	2	...	2
Other countries	3	2	3
Unascertained	11	18	34
Total	539	190	444

Table 3—Home Environment of Girls, Classified According to Mental Diagnosis

Diagnosis	Total	Favorable Environment	Unfavorable Environment	Unascertained
Normal	120	50	68	2
Dull normal	95	41	53	1
Border line	70	22	48	...
Mentally defective	125	27	89	9
Psychopathic	70	19	51	...
Psychoneurotic	26	6	19	1
Psychotic	19	4	10	5
Epileptic	10	4	6	...
Glandular case	3	1	...	2
Drug addict	1	...	1	...
Total	539	174	345	20

Table 4—Civil Status of Girls

Civil Status	Number	Per Cent
Single	475	88.1
Married	41	7.6
Separated	15	2.8
Widowed	6	1.1
Divorced	2	0.4
Total	539	100.0

Table 5—Religion of Girls

Religion	Number	Per Cent
Catholic	279	51.8
Protestant	145	26.9
Hebrew	100	18.6
None	2	0.4
Unascertained	13	2.4
Total	539	100.0

Table 6—Previous Institutional Care of Girls, Classified According to Mental Diagnosis

Number and Types of Institutions	Total	Normal	Dull Normal	Border Line	Mentally Defective	Psychopathic	Psychoneurotic	Psychotic	Epileptic	Glandular Case	Drug Addict
None	384	98	67	53	73	46	21	14	9	3	...
One institution	119	17	19	15	42	18	2	4	1	...	1
Children's home	61	9	11	9	20	6	2	3	1	...	
Reformatory	46	7	7	6	14	10	...	1	...	...	1
Maternity home	7	1	1	...	4	1	...	...	...	...	
Venereal-disease hospital	1	...	...	...	...	1	...	...	...	...	
Mental-disease hospital	2	...	...	...	2	...	...	...	...	...	...
Custodial institution	2	...	...	...	2	...	...	...	...	...	...
Two institutions	26	5	7	1	7	3	2	1			
Two children's homes	6	1	3	...	1	...	1	...	...	...	...
Children's home and reformatory	10	3	3	...	2	1	1	...	...	...	...
Children's home and maternity home	2	1	...	1	...	...	...	...	...	...	...
Children's home and mental-disease hospital	1	...	...	...	...	1	...	...	...	...	...
Children's home and custodial institution	1	...	1	...	...	...	...	...	...	...	...
Two reformatories	4	...	...	...	2	1	...	1	...	...	...
Reformatory and hospital for mental disease	2	...	...	...	2	...	...	...	...	...	...
Three institutions	9	...	1	1	3	3	1	...	...	...	...
One home and two reformatories	2	...	...	...	...	1	1	...	...	...	
Two homes and one custodial institution	1	...	1	...	...	...	...	...	...	...	
Three homes	2	...	...	1	1	...	...	...	...	...	
One home, one reformatory, one custodial institution	2	...	...	...	1	1	...	...	...	...	
One reformatory, one hospital, one custodial institution	1	...	...	...	...	1	...	...	...	...	
Three reformatories	1	...	...	...	1	...	...	...	...	...	
Four or more	1	...	1	...	...	...	...	...	...	...	
Two reformatories and "many" homes	1	...	1	...	...	...	...	...	...	...	...
Total	539	120	95	70	125	70	26	19	10	3	1

Table 7—Education of 514 Girls Seen at the Mental Clinic, Classified According to Mental Diagnosis

Grade Completed	Total	Normal	Dull Normal	Border Line	Mentally Defective	Pyschopathic	Pyschoneurotic	Psychotic	Epileptic	Glandular Case	Drug Addict
Ungraded	1	...	...	...	1	...	...	...	...	...	...
None	3	...	...	...	3	...	...	...	...	...	...
First	2	1	...	...	1	...	...	...	...	...	...
Second	2	...	...	...	2	...	...	...	...	...	...
Third	7	...	...	...	6	1	...	...	...	...	...
Fourth	15	...	2	2	10	...	...	1	...	...	...
Fifth	27	...	3	4	17	2	1	...	...	...	...
Sixth	66	4	11	14	29	3	2	1	2	...	...
Sixth*	5	1	1	1	2	...	...	...	...	...	...
Seventh	111	12	20	20	32	20	2	3	2	...	...
Seventh*	8	2	1	1	...	2	1	1	...	...	...
Eighth	126	34	29	15	17	13	8	4	4	1	1
Eighth*	35	18	8	2	...	3	2	1	1	...	...
High school 1	28	15	2	2	1	6	2	...	...	...	...
High school 2	22	9	4	1	...	5	3	...	...	...	...
High school 3	7	3	1	...	...	...	1	1	...	1	...
High school 4	15	6	...	1	...	6	...	1	1	...	...
College	1	...	...	...	...	...	1	...	...	...	...
Miscellaneous	25	6	3	4	3	5	1	3	...	...	...
Unascertained	8	...	...	1	1	2	1	2	...	1	...
Total	514	111	85	68	125	68	25	18	10	3	1

*Besides completing this grade, these girls had attended a trade or business school.

Table 8—Prevailing Type of Work of Girls, Classified According to Mental Diagnosis

Type of Work	Total		Normal	Dull Normal	Border Line	Mentally Defective	Psychopathic	Psychoneurotic	Psychotic	Epileptic	Glandular Case	Drug Addict
	Number	Per Cent										
Factory	194	36.0	26	30	37	68	18	4	4	6	1	...
Clerical	96	17.8	42	12	6	...	18	12	4	1	1	...
Domestic	107	19.9	15	21	15	34	14	1	6	1	...	...
Mercantile	41	7.6	9	9	4	7	6	4	1	1	...	...
Telephone and elevator girls	23	4.3	11	3	3	1	4	1	...	...	...	...
Professional	13	2.4	4	3	...	1	3	1	...	1	...	...
Agriculture	2	0.4	...	...	...	...	1	1	...	...	...	...
Unascertained	6	1.1	1	1	1	1	...	...	1	...	1	...
None	27	5.0	2	5	2	11	3	1	2	...	...	1
School	30	5.6	10	11	2	2	3	1	1	...	...	...
Total	539	100.0	120	95	70	125	70	26	19	10	3	1

Table 9—Last Weekly Wage of Girls, Classified According to Mental Diagnosis

Weekly Wage	Total	Normal	Dull Normal	Border Line	Mentally Defective	Psychopathic	Psychoneurotic	Psychotic	Epileptic	Glandular Case	Drug Addict
Less than $8	19	3	4	. .	6	2	.	3	1	. . .	. . .
$8, less than $10	24	4	4	6	7	. . .	1	2	. . .	. . .	
$10, less than $12	31	6	5	3	10	3		2	2	.	
$12, less than $14	57	9	12	6	19	7	1	. .	2	1	
$14, less than $16	102	23	17	16	23	13	7	1	2	. . .	
$16, less than $18	37	12	6	6	8	2	2	. .	1	. . .	
$18, less than $20	30	10	5	4	1	2	4	1	. .	. .	
$20, less than $22	17	5	4	1	3	2	. .	1	. .	1	
$22, less than $24	17	5	1	2	2	4	. .	1	2	. . .	
$24, less than $26	5	2	2	. . .	.	1	. .	. . .	. . .	. . .	
$26, less than $30	5	4	. . .	. .	. .	1	. .	. . .	. . .	. . .	
$30 and over	12	5	2	3	. .	. .	2	. . .	. . .	. . .	
Position with maintenance	52	8	10	9	13	11	1	. . .	. . .	. .	
No wage	60	14	17	5	11	6	3	3	. . .	. .	1
Unascertained	71	10	6	9	19	16	5	5	. . .	1	
Total	539	120	95	70	125	70	26	19	10	3	1

Table 10—Sources from Which Girls Were Received

Source	Number	Per Cent
District workers	168	31.2
Police department	122	22.6
Travelers' Aid Society	80	14.8
Other social agencies	48	8.9
Courts	26	4.8
Probation officers	18	3.3
Boarding homes	20	3.7
High schools	26	4.8
Disciplinary institutions	10	1.9
Relatives and private individuals	11	2.0
Outside protective association	4	0.7
State Charities Aid Association	4	0.7
New York Commission for Mental Defectives	1	0.2
Board of Health	1	0.2
Total	539	100.0

Table 11—Presence of Abnormal Traits in the Heredity of Girls, Classified According to Mental Diagnosis

Diagnosis	Total	Abnormal Traits	
		Present	Absent
Normal	120	49	71
Dull normal	95	33	62
Border line	70	30	40
Mentally defective	125	72	53
Psychopathic	70	36	34
Psychoneurotic	26	15	11
Psychotic	19	7	12
Epileptic	10	5	5
Glandular case	3	...	3
Drug addict	1	...	1
Total	539	247	292

Table 12— Offenses of Girls, Classified According to Mental Diagnosis

Offense	Total	Normal	Dull Normal	Border Line	Mentally Defective	Psychopathic	Psychoneurotic	Psychotic	Epileptic	Glandular Case	Drug Addict
Running away	189	45	40	33	39	19	6	2	5	...	...
Sex offenses	106	19	16	13	34	16	2	5	1	...	...
Incorrigibility	37	8	2	3	13	6	5	...	...	...	...
Waywardness	37	10	7	5	7	5	2	...	...	1	...
Vagrancy	18	3	1	2	6	1	1	3	1	...	...
Larceny	15	7	3	...	2	3	...	...	...	...	...
Breaking parole	6	2	2	...	1	1	...	...	...	...	...
Miscellaneous offenses	20	1	2	3	9	4	...	...	...	...	1
Total delinquent	428	95	73	59	111	55	16	10	7	1	1
Nondelinquent	108	25	22	11	13	14	10	8	3	2	...
Unascertained	3	...	...	...	1	1	...	1	...	...	...
Total	539	120	95	70	125	70	26	19	10	3	1

A SOCIAL ANALYSIS OF A GROUP OF PSYCHONEUROTIC EX-SERVICE MEN

GRACE MASSONNEAU

Psychiatric Social Worker, American Red Cross Hospital, New York City

THE basis of this study is a group of ninety-four ex-service men, all of whom were either in-patients or out-patients at United States Public Health Hospital No. 38, at 345 West Fiftieth Street, New York City, during a period of fifteen months—from November 1920 to February 1922. All of these men were in service during the period of the war, in either the army or the navy, and all have applied for government compensation, claiming that they are at present suffering from a disability resulting from their war service. They were sent to the hospital for treatment by the United States Veterans' Bureau and were referred in the course of examination to the consulting neuropsychiatrist, Dr. Robert Kingman, for diagnosis. As an aid in determining diagnosis and treatment, he requested the writer, a social worker on the staff of the Red Cross, to interview each man and obtain a detailed history of his case. This was done at the hospital under quiet conditions, and as much information as possible was obtained from each man regarding every period of his life. In a majority of cases, coöperation was easily obtained, as it was explained that the information was sought at the request of the physician and was a part of his examination. The histories have been verified in part by reports from the Home Service sections of the Red Cross. Much of the information regarding compensation has been gathered from official letters from the Veterans' Bureau in Washington. We feel that as a whole the information is reliable and that a very fair picture of the previous life and personality of each man has been obtained.

The group of ninety-four men selected for study in this paper were those for whom a diagnosis of some form of psychoneurosis was made. No cases have been included

where the diagnosis was that of some form of neurological disease, constitutional psychopathic inferiority, feebleminded-ness, ideopathic or traumatic epilepsy, cerebrospinal syphilis, tabes, or any form of psychosis.

The diagnoses made by the neuropsychiatrist for the group are classified as follows:

Diagnosis	Number	
Post-bellum neurosis:		
Psychasthenic type	3	
Neurasthenic type	3	
Hysterical type	18	
Not differentiated	19	
		43
Traumatic neurosis		6
Anxiety neurosis		6
Other neuroses:		
Sexual	1	
Cardiac	1	
Gastric	1	
		3
Neurasthenia:		
Primary	18	
Secondary	10	
		28
Neurocirculatory asthenia		6
Hysteria major		2
Total		94

These diagnoses are all subdivisions of the general classification of psychoneurosis, and the dividing line between them is not a hard-and-fast one. They are the so-called shell-shock cases which the war brought into prominence. The clinical pictures that they present have very striking similarities, the same train of symptoms being present in practically every case, with slight modifications in one direction or another. The most prominent symptoms are a generalized feeling of nervousness, lack of ability to concentrate, restlessness, insomnia, irritability, headaches—usually dull, but of long duration—depression and desire for solitude, dizziness with or without loss of consciousness, and a feeling of inadequacy. Accompanying these there are generally some somatic symptoms, such as pain in the heart or chest, shortness of breath, indigestion, or the like.

This paper aims to show something of the social history of these men, their general background before the war, the type of experience they had during the war, and their history since the war. We have picked out for tabulation information on the following points: age, birthplace and race, education, occupation before service, service record—including rank, place of service, wounds, accidents and illness suffered in service, and hospitalization during service—employment since discharge, hospitalization since discharge, and amount of government compensation and vocational training received.

The ages of the men, reckoned as of January 1, 1922, are as follows:

Age	Number	Age	Number
21 years	4	30 years	6
22 years	4	31 years	4
23 years	4	32 years	2
24 years	9	33 years	7
25 years	12	34 years	3
26 years	10	35 years	7
27 years	10	Over 35 years	2
28 years	4		
29 years	6	Total	94

The average age is found to be 27.4 years. If we assume the average date of entering service to be January 1918, the average age of the men at that time would be 23.4 years. Although we have no army figures for comparison with this table, it seems probable that the ages of these men would approximate rather closely those of the army as a whole, the largest group being found among those who entered service between the ages of nineteen and twenty-four. Twelve of our cases entered the army when thirty or more years old, which is perhaps somewhat above the army average.

Approximately three-fourths are found to be native born and one-fourth foreign born. The foreign born are for the most part thoroughly Americanized. They have been in this country for an average period of fifteen years and came here at the average age of thirteen years. Their birthplaces are shown in the following summary:

Birthplace	Number	
United States:		
New York City	35	
New York State	10	
New Jersey	9	
Pennsylvania	7	
Other states	9	
		70
Foreign countries:		
Italy	6	
Russia	6	
England	2	
Ireland	2	
Other countries	8	
		24
Total		94

The group as a whole includes two colored men, both of whom were born in the North. The number of Jews in the group is twenty. Eight of these are foreign born, six having come from Russia, one from Poland, and one from Armenia.

In tabulating the education received by the group, it is quite probable that the figures given are somewhat higher than the actual figures because, where the statement of the patient has been relied on for the information, he has been inclined to overstate rather than understate the amount of his education. The summary of the education attained by our group is as follows:

Grade Reached	Number	
Very little or no education	8	
Third grade	2	
Fourth grade	6	
Fifth grade	3	
Sixth grade	4	
Seventh grade	10	
Eighth grade	11	
Graduated grammar school	20	
One year high school	8	
Two years high school	8	
Three years high school	5	
Four years high school	1	
One year college	1	
		87
Fair education abroad	4	
Unascertained	3	
		7
Total		94

On the basis of eighty-seven cases, it is found that the average amount of education attained is the seventh grade. Over one-third of the group only reached the eighth grade or graduated from grammar school. Over one-half reached the seventh grade, but did not go further than one year of high school. These figures would probably correlate rather closely with figures for the general army group. Comparing them with statistics for a group of 48,102 drafted men, all of whom are native born and white, we find our figures somewhat lower, but it must be remembered that of our group one-fourth are foreign born. The average for the group of army drafted men is eighth grade. Those who attained the eighth grade are 30 per cent of the whole, while those who had less education than this are 41 per cent and those who had more 29 per cent. Approximately the same proportion (54 per cent) as in our group reached the seventh grade, but did not go further than one year of high school.* The average age at leaving school is found to be 14.8 years.

When the list of the occupations pursued before service was tabulated, it was found that there were thirty-five different occupations, varying greatly in the amount of skill and training required to perform them.

We have grouped them roughly as follows:

Occupation	Number	Occupation	Number
Unskilled labor:		Skilled labor:	
Laborer	6	Mechanic	8
Longshoreman	4	Woodworker	1
Peddler	1	Carpenter	3
Brakeman	1	Painter	3
Teamster	3	Butcher	1
Garage man	1	Printer	2
Stableman	1	Stonecutter	2
Messenger	1	Chauffeur	2
Tinsmith's helper	1	Steam fitter	1
Electrician's helper	1	Machinist	4
Foundry worker	1	Stove repairer	1
Laundry worker	1	Waiter	2
Iron worker	3		30
Factory worker	2		
Conductor	2		
	29		

* *Psychological Examining in the United States Army.* Edited by Robert M. Yerkes. *Memoirs of the National Academy of Science,* Vol. 25. Washington: Government Printing Office, 1921. p. 748.

Occupation	Number	Occupation	Number
Other occupations:		Seaman	1
Salesman	7	Soldier	1
Clerk	13		27
Entertainer	1	No employment because of early enlistment	2
Graduate nurse	1	Unclassified	6
Junior druggist	1		
Inspector	1	Total	94
Investigator	1		

This table would indicate that the former occupations of this group are rather evenly divided between unskilled labor, skilled labor, and other occupations which are in general of a higher type than the first two. None of the occupations is of a professional grade except that of graduate nurse. The two classes of skilled and unskilled labor together form 64 per cent of those employed.

The following table shows the number of years of employment between the time of leaving school and that of entering service. The information presented is not strictly accurate, as in many cases the patient himself could not remember how long he had stayed in his various jobs; it gives, however, a general estimate of the length of the working period prior to service.

Period Employed	Number	Period Employed	Number
None	2	13–14 years	8
Less than 1 year	1	15–16 years	4
1–2 years	9	17–18 years	1
3–4 years	12	19–20 years	0
5–6 years	22	More than 20 years	1
7–8 years	15	Unascertained	3
9–10 years	11		
11–12 years	5	Total	94

From our data we find the average number of years of employment to be 7.4 for the period between leaving school and entering service. The average length of this period is actually 8.6 years, since the average age of leaving school is 14.8 years and that of entering service 23.4. One may assume, therefore, that on the average each man was employed for all except a little more than a year of the period before service.

A rough estimate of the character of the work record, based somewhat on the type of information the man was able to

give concerning his jobs and his general attitude in referring to the subject, is as follows:

Character of Record	Number
Good	37
Fair	37
Poor	15
Unascertained	5
Total	94

This is of interest in showing that out of the group there were only fifteen whose work record was so irregular as to be classed as poor: all of the others had apparently worked with at least a fair degree of steadiness, and thirty-seven had stuck to their jobs well and been steadily employed.

When questioned regarding their health prior to service, eighty-five of the men stated that they were in good health at the time they enlisted. A large majority of them said that they had never during this period had any serious illness. Of the eighty-five, fifty-three were questioned specifically as to whether they had ever felt nervous before service, and in every case this was denied. Of the whole group, two said that they had had prior illness or injury which had to some extent undermined their health, and seven gave a history of some form of nervous trouble. Two of these seven had had chorea; two said they were nervous and sensitive when young; two gave a history of previous nervous breakdowns; and one had had "convulsions and fainting spells".

We have also considered the factor of instability prior to service, and find in the group five men (exclusive of those with a history of nervousness) who showed definite symptoms of instability. Two of these ran away from home when about ten years old, and the other three drifted from one job to another without adequate excuse. In the group as a whole, then, there are only twelve cases with a history of nervousness or instability prior to service. This would seem to indicate strongly that, as a group, these men are not notably unstable or of particularly nervous temperament. This conclusion is borne out by the general observations of the writer in talking with the men individually.

In considering the service record, we find that of the ninety-

four cases, eleven served in the navy and eighty-three in the army. We have classified them according to the rank held, giving them the highest rank attained even if they were subsequently demoted. In this table we have classed the army and navy men together, using the nomenclature of the army.

Rank	Number
Private	70
Corporal	10
Sergeant	12
Commissioned officer	2
Total	94

From this it is seen that 74 per cent of the men held the rank of private and 26 per cent a rank above that. This is a fairly high percentage of men of the rank of noncommissioned or commissioned officers. Of the commissioned officers, one was a regular army man who had been in the service seventeen years before the war and had worked up from the ranks to the position of captain, and the other was a second lieutenant in the air service. The ranks in the navy varied from gunner's mate to apprentice seaman and included four of the rank of noncommissioned officer and seven with a rank equal to that of private in the army.

With regard to the manner of entering service—that is, whether the men enlisted or were drafted—it was found that twenty-nine were drafted and fifty-two enlisted. The thirteen unascertained cases are those who were not questioned as to their manner of entering service. We should judge, however, taking into account the date of their entering service, which is known in all cases, that they would be about equally divided between enlistments and drafts. On the basis of the eighty-one cases about which we have definite information, we find that approximately two-thirds entered service by enlistment and one-third by the draft.

Since the service of the navy men was hardly comparable with that of the army, we have separated the two in this classification. The table shows where the men performed their service and what complicating factors, such as injuries, illness, and wounds, were experienced during the term of service.

NAVY

No service aboard ship:		
Physically ill	1	
Nervous breakdown	1	
		2
Service aboard ship, but never across during war:		
Injured	1	
Physically ill	2	
Nervous breakdown	1	
		4
Across during war:		
Physically ill	3	
Nervous breakdown	2	
		5
Total		11

ARMY

No overseas service:		
Physically ill	8	
Nervous breakdown	4	
Injured	7	
Not injured or ill	2	
		21
Overseas service, but never at the front:		
Physically ill	4	
Injured	7	
		11
Service at the front:		
Wounded	22	
Gassed	9	
Physically ill	3	
Nervous breakdown	7	
Injured	5	
Not injured or ill	5	
		51
Total		83

In analyzing these data, it is of interest to note how many of the group had during their service a physical injury or illness that may be regarded as a factor contributing to their psychoneurosis. The men in both army and navy groups classed as injured, physically ill, wounded, or gassed (72 in all) had such an experience. The only ones who did not have such an experience are those listed as having a nervous breakdown or as having no injury or illness. Of these cases there are four in the navy group and eighteen in the army.

Those classified as having a nervous breakdown are those

who actually broke down to such an extent that they were hospitalized. We have not included under this heading those who felt nervous while in service, but remained on duty and were not hospitalized. The total number of "nervous breakdown" cases requiring hospitalization is fifteen. Of these five broke down in this country, three aboard ship, and seven at the front. Of the latter, three attribute the breakdown to the effects of shell explosions, one to driving a team up to the front under fire, one to the effects of a series of air raids, and two report a gradual onset not due to any one factor. Of the three navy men who broke down nervously while on ships, one attributes it to the effects of practice gunfire, another to strain and exposure, and the other could assign no definite cause. Of the six men who did not go overseas, but had to be hospitalized because of a nervous breakdown, two attribute it to the strain of overwork, and four cannot account for it in any adequate manner.

Of the seven men who had no physical injury or illness and had no nervous breakdown requiring hospitalization, one attributes his present condition to overwork while in service, two to poor physical condition, and four to the horror of their experiences at the front. Of the latter, one was taken prisoner by the Germans following an attack in which his company was cut off from the rest of the troops. Before capture, he and his companions lay on the ground for sixteen hours, not knowing what fate awaited them, and this strain, he believes, caused his present nervous condition.

The number of men who during their service suffered an injury of some kind—exclusive of wounds and gas—is twenty. The injuries received were of all kinds, sprains, falls, and the like. Two were the results of airplane accidents and several of automobile and motor-cycle accidents. They were for the most part not of a serious nature. This is shown by the fact that of the twenty, three were never hospitalized and eight were hospitalized for one month or less. The average period of hospitalization for the twenty cases was slightly more than two months.

The physically ill during service number twenty-one, approximately the same number as those who were injured. Of these twenty-one, five had operations of various kinds—ap-

pendicitis, hernia, hemorrhoids, and the like. The others had such diseases as influenza, rheumatism, tuberculosis, neuritis, bronchitis, trench fever, and flat-foot. This group of men were hospitalized for longer periods than those who were injured, the average period being nearly four months. Three were in a hospital for a period of one month or less.

The number of men actually wounded is twenty-two. The nature of the wounds received varied greatly. Five of the men were severely wounded and were hospitalized for their wounds for periods ranging from ten to twenty months. Others were only slightly wounded and returned to duty after hospital periods of two or three months. The average amount of hospitalization of the twenty-two cases is approximately seven months, but only three men, with the exception of the five who were severely wounded, were hospitalized for longer than five months. One of the men listed as wounded was taken prisoner shortly after he received his wounds and spent three months in a hospital in Germany.

We have classified as "gassed" those men who were not wounded, but who were sufficiently injured by gas to require hospitalization. If a man was both gassed and wounded, we have listed him as wounded. The men who were gassed number nine. Of these only one was a severe case requiring prolonged hospitalization, while three were only slightly affected. Several of the men listed as having been ill or injured stated that they had been slightly gassed, so that the total number of men gassed is possibly somewhat higher than that given. On the other hand, there has been a noticeable tendency on the part of the men to attribute their troubles to gas when no other cause could be readily assigned.

Hospitalization During Service	Number
None	8
1 month or less	19
2 months	13
3 months	16
4 months	10
5 months	8
6 months	3
7 months	3
8 months	1
10 months	4
12 months	2
13 months	3
14 months	2
17 months	2
Total	94

This table shows that fifty-six men were hospitalized for three months or less and seventy-seven for six months or less.

Of the nine cases hospitalized for a year or more, four were severely wounded, one had tuberculosis, and the other four were hospitalized for a long period because of a nervous disorder. The average amount of hospitalization was four months.

Hospitalization Since Service	Number	Hospitalization Since Service	Number
None	20	7 months	3
1 month or less	25	8 months	3
2 months	19	10 months	3
3 months	10	12 months	1
4 months	3		
5 months	4	Total	94
6 months	3		

The amount of hospitalization since service was ascertained only up to the time of examination. Since there is a period of fifteen months between the dates when the first and the last man were examined, there was probably further hospitalization in some cases.

The average date of discharge of these men is about June, 1919, and the average period since discharge is therefore two and a half years. During this period the average amount of hospitalization, as ascertained, has been a little over two months. Comparing this with the amount of hospitalization during service, it is found that the average is just half that of the former period. In both cases it is apparent that the period of hospitalization has been comparatively small. Twenty of the group have been hospitalized since service for more than three months and only ten for more than six months. It is also noticeable that twenty have not been hospitalized at all since their discharge from service. These were men who came to the hospital as out-patients.

Period of Employment Since Discharge	Number	Period of Employment Since Discharge	Number
None	25	13–14 months	1
Very irregular	4	15–16 months	3
Less than 1 month	9	17–18 months	3
1–2 months	11	19–20 months	3
3–4 months	11	21–22 months	1
5–6 months	7	23–24 months	1
7–8 months	5	25–26 months	2
9–10 months	3		
11–12 months	5	Total	94

This table shows that during a period that we have estimated to be about two years and a half, twenty-five of these men have not been employed at all and thirty-five have been employed for periods ranging from two days to four months or so irregularly that it is impossible to give an estimate of the length of time they have worked. Of the remaining thirty-four, less than half (fourteen cases) have been employed for over twelve months. The average period of employment for the group is only slightly over five months, and during the same period the average amount of hospitalization is only a little over two months.

Our information regarding compensation is rather incomplete and what we have is somewhat difficult to analyze. Inasmuch as when vocational training is granted, the men are all put on the same basis as regards compensation, many of those who were in training said that they did not know what disability rating they had or how much compensation they would receive if they were taken out of training. The disability rating in a large majority of cases is a fluctuating thing; cuts or increases are made at the discretion of the medical board in Washington and not at any stated intervals. Another complicating factor is that the disability rating is affected by hospitalization and that a man receiving compensation on the basis of a 100 per cent rating while in the hospital may be cut to 10 per cent upon discharge. One would naturally expect to find a higher average of compensation ratings in a hospital than outside it, though it is frequently the case that the increased rating because of hospitalization is not actually received until after discharge from the hospital. We have used for the purpose of tabulation the disability rating in force at the time of examination and have disregarded earlier ratings or probable revisions.

Disability Rating	Number
Claim disallowed	9
Less than 10 per cent	3
10 per cent	9
15 per cent	4
20 per cent	8
25 per cent	4
30 per cent	3
40 per cent	3
45 per cent	1
50 per cent	3
60 per cent	2
65 per cent	1
100 per cent	16
Claim pending	14
Unascertained	14
Total	94

Of the sixty-six cases on which we have information, twenty-one are rated at 10 per cent or less disabled and forty-seven as 50 per cent or less. Those who are receiving compensation on the basis of a 100 per cent disability number sixteen. Since of the fourteen cases about which we have no information, ten are in vocational training and their disability rating is therefore presumably over 10 per cent, our figures are perhaps somewhat lower than they should be; but even making allowance for this, it is seen that, as a class, the psychoneuroties are receiving a comparatively small amount of compensation. Another factor that we have not considered here is that in many cases the disability rating is based on wounds or injuries and not on the psychoneurosis.

In making the table for the amount of vocational training received under the Federal Board by these cases, we have not considered whether or not the man was in training at the time of examination, but have listed the amount of training he has received at any time since his discharge.

Period of Federal Board Training	Number	Period of Federal Board Training	Number
None	54	16–18 months	9
1–3 months	5	19–21 months	2
4–6 months	3	22–24 months	6
7–9 months	3	Unclassified	2
10–12 months	6		
13–15 months	4	Total	94

From this table it is seen that over one-half of the group have never received any Federal Board training. Of the forty who have, twenty-one have been in training more than a year and seventeen less than a year. The two "unclassified" were in training without pay. One had been studying for five months during the evening, and the other had taken several special courses. The specific courses that the thirty-eight men have been taking vary widely. Eleven of them are studying some form of commercial work in a school; eleven are taking trade courses in electrical work, tool making, vulcanizing tires, and the like; three are studying along agricultural lines; and two are in university courses. Other courses represented are motion-picture operating, sign painting, embalming, and mechanical dentistry.

It would be of interest to know how many of the thirty-eight men in training with pay have been granted the training on the basis of a neuropsychiatric disability, but our records do not show this. We do know, however, that of this group, ten were wounded, five gassed, ten were hospitalized for injuries, and nine for illness, leaving only four cases in which the neuropsychiatric disability was the only basis for training.

Of the ninety-four men, twenty-one are married, and of the latter all except two have married since their discharge from service. As a group they are not addicted to the use of alcohol. We have evidence of alcoholic habits in only eight cases, and we do not think that the actual number is much higher than this. Two-thirds of the men have been in-patients at the hospital, and it would be difficult for one of them to indulge in alcohol to any extent without having the matter come to the attention of the hospital workers. Our statements on this point are, therefore, based more on observation than on the testimony of the men. None of the men in the group has been known or suspected to be a drug addict.

With regard to sexual habits, we have not enough information to make any statement. We do know, however, that there are very few cases of syphilitic infection in the group. All the in-patients and many of the out-patients have been given a Wassermann test in the hospital laboratory, and none of those tested had an active infection at the time of examination. There is a previous history of syphilitic infection in only one case. A small number gave a history of gonorrheal infection, but this is not of any particular significance.

Summary

We have presented here a group of men all of whom saw service in the army or the navy during the period of the war, and who have, more than two years after the termination of the war, been diagnosed as suffering from a psychoneurosis, presumably the result of their war service. The clinical pictures that they present are strikingly similar. Most of them appear to be in good physical condition, but it is evident after a few minutes' conversation with them that they are highly nervous, depressed, unsociable, and discouraged. They have many complaints and are anxious to have something

done for them, but have little initiative to do anything for themselves.

When an analysis is made of their past history to ascertain the cause of their present condition, it is found that there are as many differences as similarities. Their ages at the present time vary from twenty-one to fifty-one years, though there is a marked grouping around the average age of twenty-seven years. Three-fourths of them were born in this country, the other fourth coming from twelve foreign countries. Their educational equipment varies from none at all to a year of college work, the average man having reached the seventh grade in school. The occupations represented are about evenly divided between unskilled labor such as longshoreman, skilled labor such as carpenter or steam fitter, and more technical occupations such as nurse and investigator. The work record is in general fair, though both very poor and excellent records are found. The length of time during which the men were employed before service varies from none at all to over twenty years, the average being 7.4 years.

In the character and severity of the experiences that the men went through during the war, very striking differences are found. About two-thirds entered service by enlistment and one-third by the draft. A large majority had the rank of private, though both noncommissioned and commissioned officers are represented. Out of every five men, one never served overseas, one served overseas, but never at the front, and three were actually at the front for longer or shorter periods. Thus, for some military experience consisted of work in training camps in this country, while others went through six months of fighting in the front line, some of them being severely wounded or taken prisoner. All except twenty-two men suffered from wounds, gas, injury, or illness, and in practically every case this is in their opinion a contributing factor to their present condition. The injuries received varied from airplane accidents to tripping over a board in a training camp, and the wounds and physical illnesses were of varying severity. The average period of hospitalization during service was four months, and since discharge from service a little more than two months. Few have worked with any degree of regularity since discharge, and many have not been

employed at all, the average period of employment being only five months. At the same time they have fared very differently in the amount of compensation and training that they have received from the government. Only a fourth of them have been receiving the maximum amount of compensation ($80 a month), while about a third are receiving the minimum amount paid ($8 a month) or nothing at all. Over half of the group have never been able to take advantage of the opportunities offered by Federal Board training.

The only conclusion that can be drawn from the data presented is a negative one—namely, that as a group there is no homogeneity in the experiences of these men either before or during service. Although there can be little doubt that since the war there have been many more cases of psychoneurosis than ever before, we cannot say that any strain or stress peculiar to war service is alone responsible for the condition, since there have been examined and interviewed during the same period as the group we have presented five men who enlisted after the war period and seven who never were in service at all (civil-service cases), all of whom present clinical pictures identical with those of the men who saw war service. We can definitely eliminate as causes defective mentality, syphilitic infection, alcoholism, and constitutional psychopathic inferiority. Our judgment after interviewing many of these men would be that in a large majority of cases they would not have been picked out as in any way abnormal before service. We are, however, forced to the conclusion that there must be some temperamental or constitutional factor, some peculiar type of reaction or organization of the nervous system, which is more or less alike for all of these cases. It is quite evident that the etiological factor can be discovered only by a very searching analysis of the make-up of the individual, and that external factors cannot throw much light on the origin of psychoneurotic conditions.

PERSONNEL RELATIONS IN STATE HOSPITALS

HORATIO M. POLLOCK, PH.D.
Statistician, New York State Hospital Commission

STATE hospitals for mental disease throughout the country are remarkably well organized. The type of organization which has been built up as a result of many years of thought and experience has proved its worth through many trying periods. Its strongest feature, perhaps, is its elasticity, which permits desirable changes to be instituted without interference with the orderly operation of the institution.

Owing to certain social and economic trends which were greatly accentuated by the late war, employment problems have arisen in state hospitals that are not easily solved by present methods. The situation calls for a frank discussion of the difficulties we are facing and of remedial suggestions.

Farsighted industrial establishments in recent years have given much thought to personnel problems and have evolved methods of selecting, training, organizing, and managing employees that are producing remarkable results. Employees in many of these concerns are happy and contented and are cheerfully working to promote the success of their employers. Strikes have been eliminated, and labor turnover, breakage, accidents, sickness, and lost time have been greatly reduced, while quantity of output per employee has markedly increased.

Although every industrial establishment has its own peculiar problems, it has been found that certain principles relating to personnel are common to all. These are based on the fundamental wishes and aspirations of men and women. Employers desire that employees be competent for their respective tasks; that they follow directions and do their work willingly with skill and dispatch; that they work steadily month after month; that they take an active interest in the welfare of the plant or institution; that they coöperate with others and become effective units in the organization. Employees of the better sort desire steady but not monotonous work,

adequate wages, freedom to make decisions within their own sphere, recognition of work well done, the chance to win the respect and esteem of others, opportunity to advance, wholesome recreation and amusement, and comfortable living conditions.

Rightly viewed, the interests of employers and employees do not clash, but rather supplement each other. In well organized plants, where skillful attention is given to personnel problems, the conflict between employer and employee entirely disappears, and coöperation for the advancement of mutual interests takes its place.

To what extent may state hospitals likewise profit by closer attention to personnel problems? At present, conditions with respect to both officers and employees are unsatisfactory in most state hospitals. There is a serious shortage of physicians and a continual shifting of ward help. In the civil state hospitals of New York State on May 1, 1922, there were 167 physicians, 3,797 ward employees, and 2,674 other employees. During the previous twelve months, 61 physicians were appointed and 64 left the service, the percentage of changes based on total in service being about 37. During the same twelve-month period, 3,202 ward employees and 780 other employees were appointed, and 3,002 ward employees and 830 other employees vacated their positions, the percentage of changes being 82 and 30 respectively. In spite of this poor showing, recent statistics indicate that the New York State hospitals are more adequately manned than those of many other states. Such a large proportion of changes in the personnel of the medical staffs and of the ward service is especially to be deplored. Handicapped in this way, a hospital cannot be expected to do its work efficiently.

An examination of procedures successfully employed in large industrial establishments leads to the following suggestions:

A personnel board, to deal with problems relating to the appointment, training, assignment, management, and dismissal of officers and employees, is needed in every institution. The make-up of the personnel board would be entirely in the hands of the superintendent; in many cases it would be desirable for him to be its head. But the duties of the super-

intendent are so numerous that the direction of the hospital personnel may well be delegated to an officer who can devote the requisite time to the work. In the larger institutions it would pay to employ a trained personnel director.

The personnel board would establish standards for the various positions in the service and fix the qualifications for each position. Analysis of positions and the selection of employees for them are fundamental in any personnel plan. The whole hospital scheme of organization should be charted so that the position and responsibility of each officer and employee could be clearly seen. The chart should be subject to inspection by every person in the organization. Lines of promotion should be shown and all qualified employees should be encouraged to work for advancement.

Entrance to the service should be well guarded. State hospitals are especially well equipped to give mental and physical examinations to those seeking employment. The use of such tests to supplement the usual inquiries as to character, training, and experience would be of great service in eliminating the unfit previous to appointment. Naturally, if appointees are well fitted for positions to which they are assigned, the changes in the service will be greatly reduced.

No employee, however well qualified in a general way, is fitted to undertake the care of mental cases until he has had special training for the work. The lack of such training is undoubtedly one of the principal causes of failure of employees in the ward service.

State-hospital schools of nursing are conducted to provide a competent nursing force, but unfortunately these schools are attended by only a small fraction of the ward employees. The schools for attendants in operation in some state hospitals are usually inadequate for the purpose. The emphasis, of course, should be placed on the training of new employees, but older employees are apt to relapse into a mechanical routine unless fresh stimulus is occasionally supplied. Periodic conferences of employees engaged in the same line of work might be used to supply such stimulus.

The reduction of hours of labor in state hospitals should receive consideration. The standard day in public work outside of institutions is eight hours. The eight-hour day is

also becoming general in railroad shops, building trades, and department stores. The ten-hour day still obtains in some factories and in agricultural pursuits. The twelve-hour day is now practically obsolete except in institution work and the steel industry, and the latter, through the intercession of President Harding, is about to introduce a shorter day. The state hospitals of Illinois established the eight-hour day for ward employees about four years ago. A superintendent of one of the largest and best hospitals of that state, in an interview on the subject, said that the shortened day had given much satisfaction both to officers and employees. Since the introduction of the eight-hour day, he had been able to reduce the number of employees in his hospital about one-sixth, and the work was being done better than before. The morale of the employees had greatly improved since the shorter day was instituted.

State-hospital wage schednles need readjustment. It is generally thought that the wages provided by the present schedule in this state are adequate and in most instances fully as high as those paid for similar grades of work elsewhere. There is a question, however, whether the wage schedule ought not to make allowances for the differences in prevailing rates of wages in different sections of the state. It is well known that wages are nominally higher in New York City than elsewhere in the state. The uniform schedule, therefore, gives the up-state institutions an advantage over those of the metropolitan district.

Some extra pay allowance might well be made for the nurses and attendants who care for disturbed and filthy patients. The difficulty now experienced in keeping qualified help on such wards would be markedly lessened by an increased pay allowance.

Living conditions for officers and employees in state hospitals should be improved. Standards of living have rapidly changed in recent years. Since the era of short skirts it has been evident that the term "silk stockings" to designate the wealthy class is obsolete. The bath tub, which was counted a luxury when some of our hospitals were built, is now a necessity. That family is poor indeed that does not now enjoy a piano, a phonograph, and a radio outfit, to say nothing of the

many gas and electric devices that make the life of the average housewife a mystery and joy.

The hospital is the home of most of its employees. As such, it should supply a standard of living not far below that enjoyed by the same class of employees outside the hospital. Rooms should be comfortable and well furnished, meals should be ample, well cooked, and properly served. Opportunity for social life should be afforded. The coöperation of employees in social affairs should be encouraged, but the paternalistic attitude should be avoided. The aim should be to have the interest of employees center in the hospital and to have them regard it as their home, not as a transient boarding house.

Service records of all employees should be kept. The record of each employee should indicate his value to the institution and should be referred to whenever his transfer, advancement, or demotion is considered. The record should contain a summary of his qualifications for the position he holds, the facts concerning his appointment, training, and assignments, his periodic ratings, and other data bearing on his efficiency and desirability as an employee. The service records would be kept by the personnel board and would be used in selecting employees for promotion and transfer.

Most important of all is the morale of employees. Morale is the intangible spirit pervading a group of workers that makes for success or failure. Happy is that institution whose employees have a feeling of confidence and pride in their work, a feeling of affection and respect for their officers, and a feeling of comradeship for their associates.

Morale may be strengthened in various ways. Proper recognition of work well done and a friendly attitude on the part of officers will often work wonders. Uniforms, if neat and clean and in good repair, are of great value in maintaining morale. The uniform is a badge of distinction and authority. It sets the wearer apart from his fellows and indicates to all about him who he is and what he is expected to do. The value of the uniform is greatly reduced if it is shabby, torn, or faded. In addition to the uniform, certain distinguishing marks such as bars or stars are sometimes worn by those who have served with honor a specified length of time. Other

emblems might be bestowed for meritorious service or for unusual acts of bravery or heroism.

The individuality of the employee should be respected, and every reasonable opportunity should be given him for self-expression. Athletics, outdoor games, and social activities along proper lines will greatly aid in developing the *esprit de corps* that means so much to the institution.

With the general development of occupational therapy in state hospitals, many of the disagreeable features now attending the care of mental patients will be eliminated. State-hospital work will assume a more positive and purposeful aspect and will possess more of interest to both officers and employees.

Although handicapped in many ways in dealing with employment problems, state-hospital superintendents may reasonably hope that by the adoption of the measures relative to personnel relations clearly indicated by present conditions, the success that has attended like efforts in the industrial field will be theirs also.

INCIDENCE OF INSANITY AMONG JEWS*

JACOB A. GOLDBERG, PH.D.
Free Synagogue, New York

FOR years it has been maintained by the psychiatrical world that the Jewish race contributed more cases of insanity than any other race.[1] Of late years, however, some investigators in this field have begun to doubt this traditional view; they have found that it was not sufficiently demonstrated that the Jew differed in his liability to insanity from the Gentile, and some have gone so far as to assert that the converse is true.[2] This conclusion was also reached a few years ago by the United States Department of Commerce which stated in a report: "On the contrary, facts from which deductions can be made point rather to a comparatively smaller amount of insanity among Jews than among people of several other races."[3] Studies of the incidence of insanity among Jews have been made in a number of European countries where these people have lived for many centuries. Lombroso found that the seemingly larger percentage of insanity among Jews was not so much a matter of race as of intellectual work, for among the Semitic races in general (Arabs, Bedouins) insanity is very rare.[4] The results of a more recent study of the problem as it exists in Germany were published in 1909 by Sichel, whose deductions were based on careful investigations of the records of the Frankfort Hospital for the insane. He found that although there were relatively more Jewish inmates than the corresponding percentage of the Jewish population in Frankfort, this could be demonstrated only in reference to certain groups of mental disorders; the other types

* Excerpt from *Social Aspects of the Treatment of the Insane.* New York: Longmans, Green, and Company, 1921. 247 p.

1 Brill, A. A. and Karpas, M. J. *Insanity among Jews. Medical Record,* Vol. 86, pp. 576-79, October 3, 1914.

2 Brill, A. A. *Adjustment of the Jew to the American Environment.* MENTAL HYGIENE, Vol. 2, pp. 219-31, April, 1918.

3 *Ibid.,* p. 219.

4 Lombroso, C. *Crime; Its Causes and Remedies.* Boston: Little, Brown, and Company, 1918. p. 39.

revealed a smaller percentage of Jews than of non-Jews.[1] Studies by A. Pilcz in Vienna and C. F. Beadles in London seem to indicate a higher percentage of insanity among Jews than among non-Jews.[2] In this country Spitzka, in 1880, came to the conclusion, after a careful study of the problem, that on the whole the various forms of insanity occur in nearly the same proportions in the Anglo-Saxon, Teutonic, Celtic, and Hebrew races.[3] In considering the figures for Europe, it should be remembered that in a number of the larger European countries, as late as the nineteenth and in some even in the present century, Jews have been harassed and forced to endure unusual stresses and strains and even the torture of violent death at the hands of their persecutors. For these reasons it would hardly be advisable, for purposes of scientific knowledge and accuracy, to consider statistics gathered in such lands. The largest number of Jews within modern times congregated in a limited area are to be found in New York State and City; for this reason the admissions to the psychopathic wards of Bellevue Hospital, New York City, have been made the basis of the statistical study of the problem considered here.

Insanity in Rural and Urban Districts

The total number of first admissions to the civil state hospitals in New York for 1917 was as follows: males 3,605; females 3,272; total 6,877. Of these, 398 males and 402 females, a total of 800, were Jewish, or 11.0 per cent males and 12.3 per cent females, with a general average of 11.6 per cent.[4] The total state population in 1917 was 9,917,438,[5] the total Jewish population approximately 1,600,000,[6] or 16.0 per cent of the general

1 Sichel, Max. *Die Geistesstorungen bei den Juden.* Leipzig: 1909. pp. 43-81.

2 Jewish Encyclopedia, article *Insanity*, Vol. 6, p. 606.

3 Spitzka, Edward C. *Race and Insanity. Journal of Nervous and Mental Disease*, Vol. 7, pp. 613-30, October, 1880.

4 State Hospital Commission, Twenty-Ninth Annual Report, 1916-1917. p. 426.

5 State Hospital Commission, Thirtieth Annual Report, 1917-1918. p. 57.

6 *Jewish Communal Register, New York City*, 1917, p. 89. Alexander M. Dushkin, in *A Survey of Jewish Religious Education in New York City* (Dissertation, Teacher's College, Columbia University, 1918), places the Jewish population for New York City in 1917 at 1,500,000. Henry Chalmers, in *Jews in New York City* (*American Journal of Statistics*, 1914-1915, pp. 68-75), placed

population. In 1918 the figures were about the same—total number of first admissions, 6,797; total number of Jewish patients, first admissions, 832.[1] The figures indicate a much lower percentage of insanity among Jews in the state than in the remaining general population. It should be observed also that very close to 100 per cent of the Jews in the state live in New York City, only a small proportion living in the other cities in the state, with very few in the rural districts.

During the year 1910, the urban population of the United States contributed 102.8 admissions and the rural but 41.4 admissions per 100,000 of the population to the institutions for the insane and feebleminded.[2] An important factor having a bearing upon this question is the difference between the two portions of the population in age distribution; only 27.2 per cent of the urban population and as many as 36.3 per cent of the rural population fall in the group under fifteen years of age, a group contributing but a small fraction of the admissions to institutions for the insane.[3] The marked difference between urban and rural commitments, especially in New York State, is still further emphasized by the fact that the rate of first admissions per 100,000 population is much higher in the counties of the state in which cities are located than in those in which there are few, if any, cities of considerable size. Thus, the rate per 100,000 population for New York County in 1918 was 105.9, whereas it was only 29.9 in Warren County, 30.7 in Schoharie County, etc.[4] As aforementioned, the Jewish first admissions to the civil state hospitals in 1917 and 1918 averaged about 11.6 per cent of the total first admissions, while they formed approximately 16.0 per cent of the general population of the state, indicating a rather low rate of first admissions to institutions for the insane.

the Jewish population at 1,330,000 in 1913. The *American Jewish Year Book*, 1919-1920 (p. 605), estimates the Jewish population in New York State in 1918 as 1,603,923.

1 State Hospital Commission, Thirtieth Annual Report, 1917-1918. p. 405.

2 *Insane and Feebleminded in Institutions.* Washington: Bureau of Census, 1914. p. 27.

3 De Fursac, R. and Rosanoff, A. *Manual of Psychiatry.* New York: John Wiley and Sons, 1916. p. 15.

4 State Hospital Commission, Thirtieth Annual Report, 1917-1918. p. 438.

Jewish Insane in New York City

Another definite and perhaps somewhat more exact way to arrive at the ratio of the occurrence of insanity among Jews to their proportion in the general population is to consider the admissions to the psychopathic wards of Bellevue Hospital, New York City, for there the population is practically all urban, the admissions are all from the city proper (nearly altogether from the Boroughs of Manhattan and the Bronx), and the Jewish population is centered in the city.

The number of admissions to the psychopathic wards, male and female, of Bellevue Hospital from September 1, 1917 to August 31, 1918 totaled 6,878, of which 1,127, or 16.4 per cent, were Jews. For the following year, beginning September 1, 1918 and ending August 31, 1919, the total number of admissions to the psychopathic wards of Bellevue Hospital was 8,255, of which 1,133, or 13.7 per cent, were Jews. During the second year, as has been noted, the total number of admissions was considerably larger than the year previous. This can be accounted for by stating that directly after the signing of the Armistice on November 11, 1918, the number of cases of alcoholism and alcoholic psychoses admitted to the psychopathic wards increased considerably; also, during this year a number of soldiers who had become insane while in service in various camps in the United States were sent to Bellevue Hospital, psychopathic division, and later transferred to their relatives in the city. The incidence of alcoholism and alcoholic psychoses among Jews has been considerably less than in almost any other element of the general population of New York, and for this reason, using the Bellevue Hospital figures, the percentage of insanity among Jews was 13.7 per cent for 1918-1919, whereas it had reached 16.4 per cent the year previous. The total population of New York City in 1917 was approximately 5,800,000;[1] the total Jewish population was about 1,500,000, or 25.8 per cent of the general population, with admission rates to the psychopathic wards of Bellevue Hospital of 16.4 per cent one year and 13.7 per cent the following year.

[1] The Department of Health, New York City, estimated the total population on July 1, 1917, at 5,737,492. *Weekly Bulletin*, July 7, 1917. p. 223.

To Bellevue Hospital are brought the insane or alleged insane from the boroughs of Manhattan and the Bronx only. Kings County Hospital in Brooklyn receives such patients from the boroughs of Kings and Queens; Richmond Borough, with a Jewish population of only 5,000, sends its insane directly to Manhattan State Hospital after examination by two local physicians. A consideration of the total admissions to the psychopathic wards of both Bellevue and Kings County Hospitals for two years, thus including practically the entire city, will give a still better and more accurate index of the occurrence of insanity among the Jews of New York. The total number of admissions to Kings County Hospital psychopathic wards, from September 1, 1917 to August 31, 1918, was 2,326, of which 392, or 16.9 per cent, were Jews. For the following year, September 1, 1918 to August 31, 1919, the total admissions were 2,550, of which 429, or 16.8 per cent, were Jews, there being in both years a markedly lower rate of admissions than the percentage of the total population. For the entire city (exclusive of Richmond, which is practically negligible) the following table indicates the admissions and percentages:

Total Admissions to the Psychopathic Wards, New York City

	Bellevue Hospital		Kings County Hospital		Total Admissions	Total Jews	
End of Fiscal Year	Total	Jews	Total	Jews		Number	Per cent
August 31, 1918.....	6,878	1,127	2,326	392	9,204	1,519	16.5
August 31, 1919.....	8,255	1,133	2,550	429	10,805	1,562	14.5

In view of what has been said regarding the unusually large total admissions to Bellevue Hospital for the year 1918-1919, it might be advisable to make sufficient allowance for the increase over the preceding year by setting the total admissions at about what they were in 1917-1918. In any event, the percentage of Jewish admissions for the entire city would not average over 16.5 per cent, which is considerably less than 25.8 per cent, the proportion of Jews in the general population of New York City.

THE STUDY OF INDIVIDUALITY

CHARLES E. NIXON, M.Sc., M.D., PH.D.
Instructor in Nervous and Mental Diseases, University of Minnesota

IN the earlier psychiatric studies of the various criminal and economic dependent groups, stress was laid on the subnormal intelligence of the individuals in these groups, and feeblemindedness was thought to be the important etiological factor in the delinquency or dependency of these individuals.

The viewpoint, however, has gradually changed, and more emphasis is now being placed on abnormalities of personality in contributing to the economic or social dependency of an individual.

Adler,[1] in a study of personality and unemployment, analyzes a group of 150 individuals. Three types of personality are evident: (1) the paranoid personality, (2) the inadequate personality, and (3) the emotionally unstable type. In the second group, he states, there are a number of feebleminded individuals.

Fernald[2] emphasizes the importance of the study of character in defective delinquents. He defines character as "that component of mentality which connotes the quality thereof, in contrast to its degree—i.e., intelligence". He notes that a person is held responsible for his behavior, which is chiefly the product of character.

Healy[3] does not assent to Aristotle's point of view "that good intelligence would prevent a man from doing wrong". He believes that character and temperament have a great deal to do with conduct—good or bad.

Our understanding of the various types of socially or economically abnormal individuals has been hindered by the tendency to regard the mind as something quite apart from the bodily processes as well as from the other functions of the

[1] Adler, Herman M. *Unemployment and Personality; A Study of Psychopathic Cases.* MENTAL HYGIENE, Vol. 1, pp. 16-24, January, 1917.

[2] Fernald, Guy G. *A Method of Personality Diagnosis and Evaluation with Provision for Social-Service Propaganda. Archives of Neurology and Psychiatry,* Vol. 6, pp. 229-30, August, 1921.

[3] In a discussion of Fernald's paper. *Ibid.*, p. 230-31.

brain; indeed, the "mind" itself is looked upon as being separated into various units more or less independent.

When we consider the intricate associative systems of the brain, it is obvious that the functions of this organ cannot be divided into "water-tight" compartments, and that the various cerebral functions, such as speech, emotion, intelligence, judgment, character, motion, sensation, etc., are not independent entities.

Further, it is not the impairment of these cerebral functions—*per se*—that makes an individual a pauper, a hobo, a criminal, or a crank. A person may have defective speech, emotions, or intelligence and yet be socially and economically independent. His status is due to his *individuality,* and this is made up of the cerebral and other bodily functions; in other words, our individuality is the expression of our mental and physical status.

In so-called normal persons, there are found various grades of general and special intelligence; some have better memories, others show a more alert attention; some are possessed of more rapid mental processes, others manifest a higher grade of associative processes. In reference to the emotions and general characteristics, we note that all normal individuals fall under certain designations or show various peculiarities, as indicated by the terms selfish, egocentric, modest, conscientious, quiet, care free, inclined to worry over trifles, day-dreamer, gloomy, sensitive, quick-tempered, moody, etc. Individuals who are apparently normal also show great variations in the field of judgment. In the more definitely physical domain, there are marked differences among normal individuals—there are the well-nourished, the mal-nourished, athletes, cripples, gourmands, dyspeptics, etc. Among law-abiding and independent citizens, there are even those with definite organic diseases, such as nephritis, tuberculosis, and heart disease.

Yet, with all these differences of intellect, emotion, general characteristics, judgment, and physique, the majority of people are fairly observant of the law and economically independent.

Marked departures from the average or normal individual are found in the insane and the feebleminded. In these groups

we see the extreme exaggerations of the characteristics noted in people with normal mentality; seclusiveness becomes negativism, daydreaming becomes schizophrenia, cyclothymia becomes manic-depressive insanity, egotism becomes paranoia, mental mediocrity becomes mental deficiency. It is worthy of emphasis that in the various types of psychosis and mental deficiency more than one phase of cerebral activity is involved; indeed, the disturbance goes even further than cerebral activity—other bodily functions frequently show abnormalities. Diseases of the mind are never limited strictly to the emotions, intellect, or character.

Between the group we have termed normal and the insane and feebleminded, there is a class of individuals who do not have a definite psychosis or marked mental deficiency, but whose reactions vary sufficiently from the normal to make it probable that they will become social or economic liabilities of the community. These individuals have been grouped under such terms as dull normals, border-line feebleminded, high-grade morons, psychopathic personalities, constitutional inferiors, neurasthenics, psychasthenics, and moral delinquents.

A girl becomes an unmarried mother; she is given a mental-age test and found by this scale to have an I. Q. of 75; her delinquency is explained on the basis of feeblemindedness. The same is true of the man who fails to hold a job for any length of time or who for other reasons becomes an economic dependent.

We have notably failed to reach an adequate understanding of the factors involved in the abnormalities of this group. The reason for this is the tendency to attribute the condition to variations in one particular reaction only. As stated in the beginning of this paper, the earlier workers regarded feeblemindedness as responsible for a large proportion of the criminal and dependent classes; recently, character defect has been stressed as the important factor. Both of these explanations point out certain facts, but fail to give an adequate conception of the individual's status.

John Smith does not loaf around the pool rooms and commit petty larceny because he has an I. Q. of 75; the real explanation is that that complexity known as John Smith reacts

differently from a normal individual. This is due to his individuality, not to his mental defect *per se*—though this may be the most striking feature of his individuality. The same is true of individuals termed "psychopathic personalities". If a man's departure from the average were in the field of personality or character alone, he probably would not become dependent socially or economically. The reason that these people are misfits, failures, and criminals is because of abnormalities in more than one particular phase of their individualities; in other words, the individual as an entity is abnormal in his reactions—not that there is merely a defect in his intellect, emotions, or character.

As I have pointed out, in an animal as complex as man with his highly developed nervous system, it is impossible to have variations in one function without other functions or structures being involved to a greater or less extent.

This broader view is of more than theoretical interest, for it emphasizes the fact that a comprehensive knowledge of these groups can be attained only by a complete study of the individual—not merely by noting his general or special intelligence, his emotional reactions, his character, or his personality. It indicates a survey of all of these together, with a study of his physical make-up and general bodily condition. Any examination that makes any one of these studies more complete or accurate is of value if it is recognized that it is but a part of the general study of the individual.

As a general term including the groups outside of the normal, on the one hand, and the feebleminded and insane on the other, I would suggest the name "abnormal individuality". Additional designations may be used to emphasize the most striking abnormality, as "abnormal individuality—mental retardation", "abnormal individuality—moral delinquent", and the like.

ABSTRACTS

THE NATURE OF FUNCTIONAL DISEASE. By William McDougall, M.B., F.R.S. *The American Journal of Psychiatry*, 1:335-54, January, 1922.

The author finds, at the root of this question of the nature of functional disease, the old philosophical problem of structure *versus* function, mechanism *versus* vitalism.

From the mechanistic point of view—the point of view that organisms are simply very complicated machines—it is argued with some reason that the conception of functional disease is mistaken. The perfect working of a machine, it is held, depends upon the perfection of its spatial adjustments and of the reciprocal pushes and pulls of its material constituents, whether these be large masses or molecules, ions, or atoms. The disordered working of a machine must, therefore, always be the result of some maladjustment or spatial displacement of its material elements. And though in the case of a disordered organism, no structural defect may be visible, this is simply because it is on too small a scale; if the power of the microscope could be sufficiently increased, it would always be possible to discover a structural defect at the bottom of every so-called functional disease.

This mechanistic view of organisms, which became dominant as a result of the scientific discoveries of the nineteenth century, profoundly affected medical science, psychiatry perhaps more than any other branch. There is reason to believe that the relatively slow advance of this as compared with the other branches of the profession was due to the prevalence of the mechanistic theory. It led to the almost complete neglect of psychological study of mental patients in favor of study of their brains after they were dead, in the attempt to discover the defects of brain structure that were assumed to underlie all mental disorders. It led, further, to a sharp distinction between the psychoses and the neuroses, the latter of which were regarded as imaginary and unreal, having no structural basis that the microscope might reveal, and hence were relegated to a despised no-man's land outside the province either of the organic neurologists or of the organic psychiatrists.

Two influences contributed to change this situation. The first was the great number of cases of war neuroses, which made it clear to the profession that the neuroses are not simply the imaginary ailments of idle women of inferior constitution. The second was the work of

the psychoanalysts, who, whatever one may think of their doctrines, quickened the interests of the medical profession and of the world at large in psychological study and lifted the neuroses out of their place of neglect into the light.

In the author's opinion, satisfactory progress in psychological medicine depends upon a full recognition of functional disorders as equal to the structural disorders in importance and reality; and such recognition can come only as the result of a revision of the mechanistic conception of organisms. Yet even the mechanistic view does not bar out the conception of functional disorders. Even a machine is a purposive structure—an orderly arrangement of parts designed to fulfill a purpose. If it fails to fulfill that purpose, it may be said to be out of order, even though no structural defect be present. If an automobile, for instance, is adjusted to run at a normal temperature and the temperature falls very low, the machine may function poorly or cease functioning as a result of lack of gas in the explosive mixture; in other words, it may become the victim of a functional disorder, or disturbance of the normal balance of functions in consequence of which it fails to fulfill its purpose. Again, an automobile may suffer from functional disorder if the spark is not retarded when it is slowly climbing a steep hill. "In these two ways, then, this machine, even though all its parts be in perfect order, requires adjustment under the varying conditions of its work; and if these adjustments or regulations are not made, it suffers from functional disorder. If the machine had to work only under one fixed set of environmental conditions, it would work perfectly or normally so long as its structure was perfect; only a structural defect would produce disordered action."

Now, if the human organism is a machine, it is a machine that has to work under environmental conditions that vary often and widely. Hence it requires frequent adjustment or regulation to avoid functional disorders. "And the functional disorders from which it is most liable to suffer, perhaps all its functional disorders, are just of the two kinds which are illustrated by the automobile—namely, disturbance of the balance of functions and inappropriate timing of its functions."

But the organism differs from the machine in two ways: first, in that the purpose that it expresses is in a certain sense its own purpose, is resident in the organism; and second, in that the adjustments that must be made to meet changes in environmental conditions are made from within; and functional disorder arises when the changes demanded exceed the organism's power of self-regulation.

Purpose implies mind or mental activity. As commonly used, the term indicates purpose consciously in mind. But purposive mental actions take place on very different planes of consciousness; besides

one's clearly defined and conscious purposes, one's organism may be influenced by purposes of which one is only obscurely aware or even wholly unconscious. Functional disorders are usually the result of subconscious purposes, of the failure or disharmony of conflicting purposes that may be partly or wholly subconscious. They are still, however, mental activities. "It is, therefore, through mental influences that functional disorders are brought about. They are the consequence of disharmony, conflict, or failure of mental or purposive adjustments. That is to say, they are essentially *psychogenic*." This is generally recognized with regard to the disorders that have been officially classified as functional—hysteria, neurasthenia, psychasthenia. Indeed, the fact that they are so clearly of mental origin is the reason for their having been so long regarded as purely imaginary and unworthy of serious consideration. The real interest in the question of functional origin or psychogenesis is in connection with the psychoses, or mental diseases proper, notably dementia praecox. Typical cases of this disorder are beyond question true psychoses; if it can be shown that such cases are psychogenetic, the exponents of the possibility of psychogenesis will have won the argument.

Cases are cited by Jung and others in which the disorder seems to have been induced by mental conditions and to have been improved by mental influences. On the other hand, Sir Frederick Mott, an uncompromising advocate of the mechanistic conception of mental disease, has shown that in many cases of dementia praecox, there is evidence of a maldevelopment of the sex glands and sometimes distinct departures from the normal in the appearance of the neurones of the brain. From these facts he infers that the disease is essentially and primarily organic and structural. The author, however, suggests the possibility that the structural changes may result from rather than cause the functional disorders characteristic of the disease.

"Various observers have shown that excessive and prolonged activity, maintained through strong appeals to such instinctive tendencies as fear and rage—excited and maintained, that is to say, by mental impressions—may produce visible changes in the neurones concerned, due to excess of metabolism. That is a clear case of structural change functionally induced by mental impressions and mental activity. Why, then, should circumstances which induce the opposite kind of mental effect—namely, a checking and depression of instinctive activities—why should these not induce structural changes of the opposite kind—namely, the accumulation of lipoid granules and so forth, in consequence of diminished oxidation and metabolism? Such depression of instinctive activities through unfortunate mental influences is just what seems to be the history of the genesis of *dementia praecox* in many cases.

"No doubt in all cases in which the disease develops, and in which the structural alterations of neurones are induced, there is some constitutional predisposition which renders the patient peculiarly liable to such checking and depression of instinctive emotional tendencies; either an original defect of the vital energy or that constitutional peculiarity which Jung calls 'introversion'; peculiarities which, however, are perfectly consistent with a normal and healthy life, in the absence of the unfortunate mental influences and circumstances which lead to depression of these functions. It may well be that in some persons these constitutional defects are so marked that, in the absence of any peculiarly unfavorable circumstances, the defect of function will manifest itself and will be followed by structural degeneration. In such cases the disease would still be psychogenetic, though not traceable to any unusual mental strains, shocks, or depressing influences."

But in the case of organic mental diseases, the question whether the organic changes produced the functional or vice versa can be definitely answered only by a demonstration that changes of the one order precede in time all changes of the other order; and there is not sufficient evidence to do this for dementia praecox. That functional derangement can produce organic disease, however, the author believes to have been demonstrated during the war in the hundreds of cases of exophthalmic goiter that seemed quite directly traceable to long-continued exposure to fear-exciting conditions. If such pronouncedly organic changes as those of this disease may be psychogenetic, why, the author queries, should one hesitate to assign a similar origin to mental diseases if the facts seem to warrant it? He feels that both the manic-depressive and the epileptic insanities may be of functional origin, even though, when they are well established, chemical and structural changes play an important part in them.

Two further questions, both of which are sometimes confused with this of the functional origin of mental disease, are touched upon by the author. First, can mental disease be not only psychogenetic in origin, but functional in nature, without any organic changes secondary to the functional disturbance? The author is inclined to believe that this is possible—that a disturbance of balance of functions may tend to perpetuate itself without involving any pathological changes in tissue. Second, can there be a disorder of the mind alone, unaccompanied by any disorder of the body? This is the old-fashioned view of mental disease, and the author feels that there is ground for not rejecting it without consideration, believing that "the mind has a nature and a structure and functions of its own which cannot be fully and adequately described in terms of structure of the brain and its physical processes. And if this be true, it does not seem logically

impossible that this nature of the mind itself may be disordered or impaired or defective."

The three possibilities under the conception of functional disease are, then: "(1) Diseases which, though involving structural and chemical abnormalities, are of functional origin. (2) Diseases which are of functional origin and of functional essence, involving no strictly pathological tissue change, but only a disturbance of the quantitative balance of functions. (3) Mental diseases which are of the mind only and not at all of the body."

Social Service and Out-patient Relations. By John B. Macdonald, M.D. *American Journal of Psychiatry*, 1:141-57, October, 1921.

This is a short discussion of community work in connection with state hospitals in general and, in particular, of the out-patient and community-service work of the Danvers State Hospital (Hathorne, Mass.), of which the author is superintendent. The value of the state hospital to the community is, Dr. Macdonald states, to be measured less by the work that is done within the walls of the hospital itself than by what is accomplished in the way of restoring patients to social or economic usefulness through after care and supervision, and by the part that the hospital plays in the conservation of the mental health of the community through medical advice and direction of a preventive nature and through education of the public in the principles of mental hygiene. All these important extramural activities Dr. Macdonald includes under the term out-patient and community service.

Of this service at the Danvers State Hospital, he writes: "Our out-patient and community service is organized along medical and sociologic lines, and aims at the clearest understanding of mental conditions through the combined efforts of medicine, as represented by the physician, and the study of environmental or social conditions, as carried on by the social worker. The social-service department occupies the position of an auxiliary to the medical, under whose general control and direction its activities are conducted. . . .

"No one will question the statement that to be truly effective psychiatric work demands not alone expert medical service, but also expert social service. He who would understand mental disorders rightly must not confine his observations to the study of function or symptoms by the bedside or in the laboratory. He must see his patient in his social setting; he must possess some knowledge of the personal and human aspects of his condition. He must know him as he appears in his ordinary daily life, in his pleasures and difficul-

ties, emotions and reactions. Nothing can be considered too insignificant for his notice which is not too insignificant to illustrate the operation of laws of health and mental evolution; and this is the contribution of our allies, the social workers, to our studies and adjustments of social-psychological conditions in their relation to mental welfare. I have said that the social workers should be under the control and direction of the medical department; but because, through their contribution, they have humanized our knowledge; because they have broadened the basis of our studies and added greatly to our resources in the way of treatment and adjustment; because they have brought us into intimate touch with the community, the relationship should be one of friendly coöperation, mutual understanding, and respect, with adequate scope for initiative and individual judgment."

A general policy of social work has been outlined for the state hospitals of Massachusetts by Miss Hannah Curtis, Director of Social Work under the Department of Mental Diseases.

This outline gives first place to social case-work—"the interweaving of medical treatment and social service upon the basis of personal knowledge of the patient in his whole environment". Then follow (2) systematic home visiting, including frequent visits to patients that require special supervision and quarterly visits to boarding patients; (3) the taking of histories, medical and social, both inside and outside of the hospital when required; (4) investigation of home conditions of special patients, of complaints entered at the hospital by patients or outside persons relative to outside affairs of patients, of all applications for boarding patients, of criminal cases referred by courts for observation, of special employment problems; (5) the placing and care of boarding patients, selection of homes, after-care work; (6) out-patient clinic work; and (7) educational work through lectures, conferences, special courses, publications, research work, and training of students and volunteers.

To illustrate what is being accomplished by this alliance of medical and social forces, Dr. Macdonald gives some of the results that have been noted at Danvers. One of the most striking of these is the steady increase of patients on visits or parole in the community. "In 1910-1911, without social-service supervision, the number of visits was 21.6 per cent of the daily average population. Under social supervision, the visits increased 26 per cent in 1912-1913, 28 per cent in 1913-1914, 36 per cent in 1914-1915, 33 per cent in 1915-1916, 31 per cent in 1916-1917, while during the period of 1917-1918, when for a considerable portion of the year the hospital lacked the services of a social worker, the percentage dropped to 24 per cent. (It is

well to note that the average number of visits before the social-service era varied as a rule between 17 and 21 per cent.) In 1910-1911 the total duration of all visits extending over one week was 48,316 days, with an average daily population of 1,452 in the hospital; in 1912-1913, the total duration rose to 50,636 days, for an average daily population of 1,450; in 1914-1915, 63,113 days for an average population of 1,490; 1916-1917, 68,016 days for an average population of 1,501; while in 1917-1918 (mostly without social work) the total duration of visits dropped to 53,222 days for an average population of 1,488. In 1918-1919, with a restored service, the total duration of visits rose to 66,641 days for an average population of 1,486.

"Another thing noticeable is the marked increase of total visits, that is all visits, including those of less than one week's duration. In 1910-1911, the total number of persons on visits was 424, and this represents a fair average of pre-social-service times. Since that time the numbers of visits for successive years have been 467, 536, 637, 780, 699, 676, 690, 702, 748.

"Though it be true that in most of our methods we are apt to be as conservative and individualistic as the men of years ago, yet the leaven of medico-sociological relations is gradually bringing about the socialization of medicine. Nowhere is this effect more apparent than in the state-hospital field. The opportunities for helpful assistance to the medical department and the need of such assistance is strikingly exemplified in a survey of the year's work at Danvers by the head social worker, Miss Bertha C. Reynolds. Three hundred and twenty-two persons were dealt with by the Social Service Department. Two hundred and fifteen of these had never before been referrd to the department. The sources of new cases were as follows: 67 per cent referred by physicians of the hospital, 33 per cent by outside agencies, such as other hospital social-service departments, family welfare societies, children's aid societies, friends of patients, the Department of Mental Diseases for special after care or investigation, etc. The 33 per cent referred by agencies outside the hospital contains its own commentary as to the progress in community relations since the old days of detachment, which happily had their termination with the organization of the present system.

"The problems for the solution of which the assistance of the social-service department was enlisted were in the following proportions; connected with disease, mental or physical, 46 per cent; connected with environmental or social conditions, 54 per cent, this including such things as poverty, environmental ill-adjustment, sex problems, employment problems, family dissensions, legal difficulties,

moral problems, supervision of drug addicts without psychosis, supervision of alcoholics without psychosis, wayward tendencies, vacillating interests, temperament, criminal tendencies, etc.

"What was really accomplished for the patients by coöperative medical and social efforts? Nothing is more difficult to estimate statistically, is Miss Reynold's comment. But a basis for estimate may be formed from the variety of services rendered. These include arrangements for medical care; readjustments in home, in work, in recreation, in church matters; arrangements for community supervision; plans arranged with relief agencies, with special agencies, with venereal-disease clinics, with employment agencies; legal aid secured; advice to patients; advice to relatives; contribution to diagnosis; contribution to decision in regard to discharge; contribution to morale; visiting and supervision of boarding patients; advice to social agencies; information to social agencies; assisting Red Cross with soldiers' compensation claims, etc. . . .

"Again, a survey by Dr. Butterfield of patients discharged under social-service supervision during the year 1917-18, shows 157, or 63 per cent of the whole, who have since been able to live in community life. . . . An inquiry as to the economic success of those discharged (total 250), shows 100 self-directed under social-service assistance and advice, 74 responsible for others, and 72 requiring social-service direction. Under social-service supervision, the discharges of 1917-18 have been 76 per cent successful, with only 24 per cent failures in three years."

Training Aids for Mental Patients. By Eleanor Clarke Slagle. *The State Hospital Quarterly*, 7:167-74, February, 1922.

This paper is one of a symposium on occupational therapy read at the quarterly conference of state hospital managers and superintendents of New York and the State Hospital Commission at Manhattan State Hospital, December, 1921. The other papers, all of which are published in this same number of *The Quarterly*, are as follows: *The Teacher Problem in Occupational Therapy*, by Dr. Richard H. Hutchings, Superintendent, Utica State Hospital; *The Financial Aspect of Occupational Therapy*, by Dr. William C. Garvin, Medical Superintendent, Kings Park State Hospital; *Development of Occupational Therapy at Gowanda State Hospital*, by Dr. Clarence A. Potter, Superintendent; *Organization of Occupational Therapy in a State Hospital*, by Horatio M. Pollock, Statistician, State Hospital Commission.

In training aids for mental patients, Mrs. Slagle lays it down as a general principle that the emphasis all through the training should be placed upon "the relation of directed activity to mental adjustment and social rehabilitation". The term social rehabilitation is used with reference to three distinct groups of patients—one group that will in all probability spend the rest of their lives in the hospital, a second that may be returned to community life, and a third that may be profitably treated in a pre-hospital work clinic, with the idea of preventing hospital experience.

Candidates should be selected for the training course instead of the course being selected by persons who feel that they are fitted for the work. The selection should not depend upon the judgment of one person, but upon the combined judgment of a committee whose business it is to know all the requirements. Of prime importance in work with mental patients is the factor of personality. This term, so difficult to define, includes such qualities as gentleness, patience, vision, the ability to be honest and firm, abundant common sense, and adaptability or the power to live, for a time at least, in the world of the patient. "If by chance, the patient happens to be 'the Bride Adorned' or 'the Queen of Sheba' or the 'Special Emissary of the President', an ability to fall in line as one of the Honorable Subjects of so exalted a personage will often be an entering wedge in creating an interest in normal activity."

Occupational therapy for mental cases necessarily includes work with the group of deteriorated or deteriorating patients—notably the large group of dementia-praecox patients—to be found in every state hospital. The course for aids who plan to enter this field should, therefore, include habit-training work. The student should be shown how our lives are for the most made up of habit reactions and how occupation may be used remediably to overcome some habits, modify others, and construct new ones, to the end that habit reactions will be favorable to the restoration and the maintenance of health. She should be taught to bear always in mind, in work with mental patients, the necessity of requiring attention, of building on the habit of attention until it becomes application, voluntary and agreeable.

After habit training, the next step in the rehabilitation of the patient is kindergarten work. Prospective teachers must be taught kindergarten methods as applied to a reëducational program—what ways and means can be used to stimulate the special senses. "The employment of color, music, simple exercises, games, and story telling along with occupations, the gentle ways and means in use in educating a child, are equally important in reëducating the adult."

In advancing the patient from kindergarten through the various grades, the underlying pedagogical principle to be observed is that tasks must be of increasing interest and require an increasing degree of concentration. Finally, in the occupational center, or "curative workshop", the prospective aid has the satisfaction of using to the full the craft knowledge gained in her technical studies and of seeing really beautiful work accomplished. The author adds, however, that while occupational therapy is training, it is not vocational training *per se,* and that the manufacture of salable articles in a hospital does not indicate that the maker will, upon his discharge, earn his livelihood at that kind of work.

Upon introduction to the occupational-therapy department, students should be made familiar with the plan of hospital administration and should be instructed in hospital etiquette and the ethics of professional behavior. They should be given the opportunity also to take part in all the physical work, even assisting in the gymnasium, and should be made to realize the importance of this work of creating or recreating the play spirit as part of the occupational program.

Instruction in the care of equipment and in the utilization as well as in the buying of materials, in note taking and in the keeping of forms and records, are other points covered in the training.

In conclusion the author states that in her observation all the existing schools of occupational therapy provide good medical, social, and craft courses, and that the majority of aids understand crafts, but that the application to mental patients must be taught by some one fully acquainted with the needs in this field.

Criminal Records and Statistics. By Horatio M. Pollock. *Journal of Criminal Law and Criminology*, 12:514-17, February, 1922.

In its annual report for the year 1919-1920, the Committee on Statistics of the American Institute of Criminal Law and Criminology presented a plan for the preparation of uniform statistics in institutions for criminals and juvenile delinquents. During the following year, the committee devoted its attention to ways and means of putting into effect the proposed plan and to the development of a scheme for securing better judicial criminal records and statistics. As a result the conclusion was reached that little is to be hoped for from the voluntary coöperation of institution and court officials. The plan for uniform statistics in institutions was submitted to the heads of prison departments throughout the country, but so far as is known, has been adopted only by the state institutions for criminals and delinquents in

Illinois and by two institutions in the state of New York. With regard to judicial criminal statistics, the situation is even worse, owing to the frequent changes in the personnel of county and city courts, and to the general lack of interest in anything connected with statistics on the part of court officials. So far as the committee was able to ascertain, no state bureau is collecting all the data it should concerning crime and criminals, and there is little coöperation between bureaus in different states; yet enough work is being done in many states to secure good results if the work were properly organized and directed. In its present report (November, 1921) the committee outlines the steps that it considers necessary if satisfactory data concerning crime and criminals are to be secured throughout the country:

"1. Every state should have *one* central bureau of criminal records and statistics to which all penal institutions, criminal courts, police departments, and parole, probation, and prosecuting officers should report on prescribed forms. In one state five separate bureaus are compiling criminal statistics and each bureau is practically ignoring the work of the others. Work of this kind must be centralized to be effective.

"2. A branch bureau under the general supervision of the state bureau should be maintained by every large city. Large cities need, for purposes of administration and crime prevention, a considerable amount of local data that would be of little interest to other localities. These data would be compiled by the branch bureau in addition to its work for the state bureau.

"3. The state bureau should establish a system of forms, records, and reports to be used by branch offices and by all recording and reporting officers throughout the state.

"4. The state bureau should provide a statistical manual explaining the system and should employ experts to instruct and assist recording and reporting officers, so that uniform standards might be maintained throughout the state.

"5. Reasonable specific compensation should be given to all officers reporting to the state bureau.

"6. Penalties should be prescribed by statute for failure to keep the required records or to report at the specified time.

"7. A competent statistician should be placed at the head of every state bureau. The importance of the work and the difficulties involved demand expert direction.

"8. There should be the fullest coöperation between state bureaus throughout the country and so far as possible all bureaus should use the same system. This is essential if we are ever to get good national statistics of crime and criminals.

"9. Every state bureau should publish an annual report containing a series of standard statistical tables.

"10. Every state bureau should report to the Federal Census Bureau as soon after the close of each year as possible, such reports to be uniform and to be based on data collected according to a standardized plan.

"11. The Federal Census Bureau should issue a yearly bulletin of criminal statistics which should be available to the public within a year from the close of the period to which it relates. Such a bulletin would of course include only the states that were compiling and reporting satisfactory data.

"12. Statistics of crime collected by state bureaus should give complete classified data of crimes reported to police officials and prosecuting officers, showing for each principal group of crimes the arrests made, the trials held, and the convictions resulting therefrom. These data should be given for the state as a whole and for each county and important city.

"13. Statistics of criminals in general would necessarily be limited, but more adequate data could be secured concerning convicts sentenced to state institutions. The plan proposed last year would serve as a basis for institution statistics.

"14. Criminals convicted for the first time should be separated in statistics from recidivists and each class should be carefully studied.

"15. Every state bureau should maintain an identification file of Bertillon measurements and finger prints, and there should be active coöperation between bureaus in exchanging records and in identifying prisoners.

"16. Every state bureau should be a bureau of information concerning all matters pertaining to crime and criminals and should lend assistance to courts and police officers.

"17. The Federal Government should coöperate in this movement for better statistics of crime and criminals by establishing in the Census Office at Washington a bureau that would compile adequate data of crime and criminals under federal jurisdiction and that would receive and consolidate reports from state bureaus, as above outlined."

The committee recommends that a model law relating to the establishment of state bureaus of criminal records and statistics be prepared by the institute, and that an effort be made to secure its adoption by the several states.

BOOK REVIEWS

Guides for History Taking and Clinical Examination of Psychiatric Cases. By George H. Kirby, M.D. Utica: State Hospital Press, 1921. 83 p.

It is, of course, difficult to unify impressions about such a collection of details as is found in these outlines of psychiatric examinations as developed in the New York state hospitals. The need of method and technique in psychiatry is evident, and all objections to a standardized method are ably answered in the pages of this manual. There is no intention to interfere either with the patient's anxiety to tell his own story in his own way, or with the physician in exercising his full judgment as to what to press and what to omit. The importance of covering a definite minimum and of thinking over thoroughly whatever is omitted cannot be overstated.

There are a number of pages on history taking in which the fact is recognized that the history should grow as do the medical notes and that valuable histories come in months after the admission of a patient, and on top of a history that already seems full. The features made most prominent in the guide are studies of personality, of preferred reactions—"which actually serve to guide an individual into a psychosis"—and of the endocrine make-up. In the physical-examination scheme, not much attention is paid to the part that may be played by non-psychiatric specialists—the roentgenologist, for instance—in the search for infections. In regard to the mental examination, it is brought out that some patients are accessible only on the day of admission and on the day of discharge. In these mental examinations we are always doubtful between the Scylla of monotonous question and answer and the Charybdis of—not what the driving forces and sequences of events are, but what the physician thinks they are.

The book is too large for the pocket and should be supplemented by the examiner's own pocket manual.

Earl D. Bond.

Pennsylvania Hospital, Philadelphia.

Women Professional Workers. By Elizabeth Kemper Adams, Ph.D. New York: The Macmillan Company, 1921. 467 p.

In 1910 a volume entitled *Vocations for the Trained Woman: Introductory Papers* was issued by the Women's Educational and

Industrial Union of Boston, containing brief descriptive articles on occupations other than teaching. It was followed later by two volumes devoted to intensive studies of opportunities for women in agriculture, social work, secretarial work, real estate, and domestic science. "The present volume", the author says, "is an attempt under the same auspices to survey the field afresh in the light of a decade of active development culminating in the experiences of the war." Schedules of inquiry that were filled out by professional women and their employers form the basis of the book. It is evident that many other sources were tapped. In addition to the great amount of information furnished by the text itself, there are numerous detailed references.

The first chapters contain a thorough study of the change in the meaning of the word professional, followed by a discussion of the relation of women workers to the professional group. Subsequent chapters are devoted to descriptions of the various professions in which women are engaged, together with detailed analyses of the duties connected with them and suggestions as to qualifications for them. One is somewhat surprised at the number and variety of professions that are now attracting women. The last chapters are devoted to methods of securing employment, with a brief review of the history and present status of vocational bureaus, valuable suggestions for women professional workers, and a selected and annotated reading list.

The reviewer is particularly interested to observe the emphasis placed upon mental hygiene. Such topics as the mental-hygiene movement, human behavior, psychiatrists, psychologists, psychiatric social workers, occupational therapists, mental tests, school clinics in mental hygiene, special classes in the public schools, and the mental aspects of juvenile delinquency are presented. To persons actively engaged in the field of mental hygiene the following views expressed by the author will be gratifying: that in college departments of health at least one doctor should be a specialist in mental medicine; that a practical course in mental hygiene should be included in the training-school teaching of all nurses; that all health workers should have more training in psychology and in mental hygiene; that every probation officer or other worker with delinquent or wayward women and girls should know both the medical and the mental elements involved; and that health centers should include mental-hygiene clinics. Readers of MENTAL HYGIENE may be interested in the following statement: "No case-workers of any type, including teachers, can afford to be ignorant of the quarterly entitled MENTAL HYGIENE, issued by the National Committee of that name."

In speaking of opportunities for women physicians, the author states: "Antituberculosis work has long been a meeting ground of doctor, nurse, and social worker. The new fields of social hygiene and mental hygiene call imperatively for the intimate coöperation of doctors, nurses, teachers, social workers, civic workers, industrial relations workers. . . . Women psychiatrists are needed in many fields, especially in protective and corrective work with women and girls, in education, and in industry. Hitherto their opportunities have been chiefly in connection with mental hospitals. But more general recognition of the prevalence of unstable and psychopathic persons in the community and of the value of preventive work with children and young people is greatly enlarging these opportunities and calling for a new type of training and experience. Some women psychiatrists have already established themselves as independent practitioners and consultants."

In one of the chapters dealing with social service, the following significant paragraph is found:

"But case-work is being more fundamentally strengthened by several independent movements, the social bearings of which grow steadily more apparent. Chief among these are (1) the mental-hygiene movement, which deals with emotional and volitional conduct disorders and their prevention; (2) the movement for intelligence tests of people of different educational and occupational groups to discover inferior, average, and superior native ability; (3) the vocational-guidance movement, which seeks to relate individual aptitudes and occupational requirements and resources; and (4) the employment or personnel management movement, which seeks to utilize the results of the first three movements in promoting industrial productivity and the personal satisfactions of the individual worker. All these movements are based on the case-work view that expert study of the individual is requisite for satisfactory adjustments and readjustments in practically every type of social situation. It is a theme for the satirist that persons who would shudder at being considered 'cases' in the ordinary social-service sense plume themselves upon having been 'psychoanalyzed' or 'mentally tested'. The psychiatrist and the psychologist are doing to some extent for the well-to-do what the case-worker has done for the poor. They strongly reënforce the view that preventive and educational work must begin with the child; and also give warning of the damage done by clumsy and unskilled handling of problems of personality and conduct. . . . "

The data furnished by the schedules of inquiry are presented in a manner that is both interesting and convincing. Comments incorporated in the schedules, at times frank and illuminating, are freely

quoted. Into these are skillfully woven the views of the author, which are expressed in a scholarly and stimulating manner. The book should be especially valuable to the undergraduate in choosing her profession, to vocational advisors, to educators, to employers, and to all women who are or hope to become professional workers.

EDITH M. FURBUSH.

The National Committee for Mental Hygiene.

WHAT IS SOCIAL CASE-WORK? By Mary E. Richmond. New York: Russell Sage Foundation, 1922. 260 p.

It will be interesting to watch the reaction of social workers in general to Miss Richmond's book. If they accept her point of view, then social work has moved a long way. One feels reasonably safe in predicting the reaction of psychiatrists and psychiatric social workers. The reaction will be one of surprise—agreeable surprise so far as most of the book is concerned, but surprise with a little amazement at the rest of it. That Miss Richmond, out of the richness of her experience, has come to define social case-work as she does will certainly come as an agreeable surprise; that, having progressed so far, she stops short and falls back eventually on what I am sure she would consider the inadequacy in the work of the early volunteer charity worker will bring some up with a short breath.

Social work as we know it to-day is, of course, a development from the work of the volunteer charity worker of a generation or so ago, whose interest was in ameliorating the condition of the poor. Her primary interest was frequently religious; she was an untrained worker and the impulse that brought her to the work was frequently a sentimental one. She dealt with "relief"; causes did not interest her. Her tools were kindliness of heart, pity, a desire to help, and such funds for "relief" as she could gather. From these beginnings has developed social work as we know it to-day—a trained body of workers who choose their profession as another may choose his; who are interested in the relief of suffering, but who study their problems in a large way, searching out fundamental causes and endeavoring to modify these, rather than focusing their attention on each case as an isolated case; who believe in helping others to help themselves rather than in a pauperizing process that comes of the indiscriminate doling out of funds.

The object of social case-work, says Miss Richmond, is the developing of personality. In other words, allowing for certain extraneous causes that may be at work in any given case, the chief difficulty is likely to be found in a defect of personality that makes it difficult or

impossible for the individnal to meet certain critical situations. The object of the social worker, therefore, must be, according to Miss Richmond, not that of another extraneous force that comes in to neutralize temporarily the other forces, then to remove itself to await the next crisis, but the object should be so to develop and strengthen the personality of the client that the next crisis will be met by a different individnal—an individual better able to cope with a crisis.

Dr. Southard reviewed Miss Richmond's first book, *Social Diagnosis,* and pointed out that although no note seemingly was taken of it, over half of the cases recorded in the book showed unmistakably that psychiatric problems were involved and that one was merely fumbling with such cases as long as this fact was unrecognized. One wishes that Dr. Southard were here to review Miss Richmond's present thesis. He might question her use of the term "personality", wondering a bit if that is just the term she wants; but he would not quibble over such a matter. He would rejoice at the direction Miss Richmond's thought has taken.

But here Miss Richmond stops. The social case-worker is to develop personality. What are to be her tools? Shades of the volunteer charity worker in the crinolines of the 1850's! Kindliness, patience, a spirit of helpfulness, and an "intangible something that passes from mind to mind". To accomplish her main job, then, the case-worker must fall back upon the inadequate tools of the early worker in volunteer charity. What can Miss Richmond mean? Does she mean that there are no other tools available, that personality is a vague and mysterious thing, and that it can only be dealt with in a vague and mysterious way? If so, she puts an impossible burden upon the case-worker. The examples she gives of what she means are not always reassuring—walking the streets all night with a woman to keep her from drinking; that may have been kindly, but it seems a bit inadequate. It would seem to belong to the cup-of-cold-water period. Certainly all the qualities Miss Richmond mentions are needed by a social case-worker, but it might help if, in addition, the case-worker got away from some of her mysticism and learned something about personality, about some of the dynamic forces that are at work in an individual, whether a social worker or a client, both to warp and wreck and to make fine and beautiful.

Is it to be inferred that Miss Richmond knows nothing of these things, that she is unaware that progress has been made in the understanding of personality since 1850? No such inference can be made, we feel quite sure. One gets from between the lines that Miss Richmond has read broadly on these subjects. She knows about these

things, but she is not yet convinced. Thus far, she feels sure; beyond, she is not so sure—and, quite rightly, does not venture. But one believes that she is thinking considerably past the point at which she stops in her writing. She is thoughtfully feeling her way—and social work will be the gainer both for her conservatism and for her thoughtfulness.

There is a possibility, of course, that Miss Richmond's thought will crystallize at this point and that she will make no further progress. But one does not entertain this view for a moment. One expects a third book—a book that will be as far in advance of this book as this book is an advance of *Social Diagnosis*. This is to disparage neither *Social Diagnosis* nor the present book. The reputation of the first is too well known to need defense, and the latter marks an important step forward in the philosophy of social work. It is merely to record what any of us might be glad to have recorded of us—that our work shows a consistent growth—and what any of us might be glad to have hoped for us—that the end of our growth is not yet.

Frankwood E. Williams.

The National Committee for Mental Hygiene.

The Trend of the Race. By Samuel J. Holmes, Ph.D. New York: Harcourt, Brace, and Company, 1921. 396 p.

If politicians are divided into two groups—those who "point with pride" and those who "view with alarm"—biologists on the whole are unanimous in their viewing with alarm the trend of modern civilization. Dr. Holmes is no exception to this rule. He also sees in certain phenomena of present-day civilization a trend toward race degeneracy.

In his introductory statement, he says that a person with our present knowledge of human heredity, and endowed with the authority which the great master in Campanella's *City of the Sun* exercised over the matings of men and women, could produce in a few generations a remarkable array of diverse types. He could, for instance, breed an Albino race and then raise a feebleminded race, an insane race, a race of dwarfs, a race with hooklike extremities instead of hands, a race of superior intellectual ability, or a race of high artistic talent.

The reviewer mildly begs to differ with the above introductory statement. He does not believe that an insane race or a race with hooklike extremities instead of hands, and especially a race of superior intellectual ability, could be bred, to say nothing of a race of high artistic talent.

A woman to whom a good deal of this book was read said: "Too

many of the biologists talk in arithmetical terms instead of in algebraic as they should. In arithmetic x=10, in algebra x=unknown. They have many x's in their calculations, but the one error they make is to believe that they are 10 instead of unknown." This is introduced to emphasize the fact that the author who is not a psychiatrist or a medical man serenely speaks of insanity, feeblemindedness, and delinquency as if they were nice, easily juggled characters instead of constituting ranges and ranges of problems of entirely diverse natures. For this he is not to be blamed, since a good deal of the psychiatric thought in America has taken the same attitude, which is essentially a layman's attitude. But there is no such thing as insanity, no such thing as feeblemindedness, no such thing as delinquency; these are mere terms used to cover entirely different types of conditions, and many of the statements current to-day are based upon the works of biologists, not medical men, such men as Davenport and Goddard.

And here again we meet the famous Kallikak family. The reviewer must confess that a sense of incredulity is raised to the *n*th power whenever he hears of the two lines of descendants of Martin Kallikak. On the one hand, he bred a family absolutely bad, and on the other a family absolutely good. The whole story is too good to be true. Nothing like it is seen anywhere else. Everywhere else one finds, instead, good people breeding bad people and bad people breeding good people. Saints are descendants of prostitutes and prostitutes are sprung from the loins of saints, but not so with Martin Kallikak. By marrying into a respectable family, he had nothing but respectable descendants; by having illegitimate relationships with a feebleminded girl (who made the diagnosis after a century had passed?) he had nothing but feebleminded and delinquents. If this story is true, it is too exceptional to be of any value. Dr. Fernald's recent paper on the descendants of some of his feebleminded show that they are quite capable of breeding normal people, and any one who has had any clinical experience knows that feebleminded people appear without any definite known cause in the very best of families, biologically speaking. It is far too early for us to make Mendelian laws for that group of x's we call feeblemindedness and that group of more mysterious x's we call insanity.

However, it may be said that Dr. Holmes does not quite swallow all that has been said on this matter, but takes it with a grain of salt. The only quarrel the reviewer has with him is that he should, instead, have taken it with a ton of salt.

There is a very interesting chapter on the inheritance of mental ability, based mainly upon the work of Galton, but also that of Woods

and Davenport. His concluding paragraph is interesting; I quote part of it: "Great men, it is true, seem to rise further than their source. Generally they come from ancestry considerably above mediocrity, and I venture to express the opinion that a great man has never been produced of parents of subnormal mentality. A great man is more apt to rise if both parents are of very superior ability than if one parent is not above mediocrity." The author quotes, of course, the cases that are well known—the Darwin family, the Balfour family—as examples of families in which great mental ability was a persistent quality. To the reviewer, these families seem the exception rather than the rule, and there are very few examples of great ability persisting for more than one or two generations. To the reviewer it seems that the great man is a sport, a variation, and to be accounted for on that basis rather than as an example of true heredity.

An exceedingly interesting series of chapters deals with the birth rate and its decline. Here Dr. Holmes is on sure ground, for nobody can deny that the birth rate is dropping, and furthermore no one can deny that the more successful limit their families more than do the non-successful. Whether or not that disparity will exist in another generation or two, when the knowledge of birth control has spread throughout the community, is an open question. The reviewer has watched the decline of the birth rate amongst immigrant stocks and has found it to exceed that of the native stocks only for a generation or two; then the descendant of the immigrant becomes thoroughly Americanized and has as small a family as his Anglo-Saxon compatriot. However, at the present time it seems unquestionable that a rather serious biological fact is contained in the observation that the birth rate of those who seem to be the better human types is much lower than those who seem to be the poorer human types.

In the chapter on natural selection in man, the biological point of view is quite pronounced. All the biologists seem almost to rejoice in the high infant death rate, for they look upon it as a selection of the unfit. The fact that it is secondary to bad feeding and poor care does not daunt them, for they promptly conclude that these factors are due to the low mental level of the parents, and therefore are part of the inferiority of the unfortunate infants. That a large majority of immigrants are slum dwellers at first, and that the slum dwelling is a result of their situation as immigrants rather than of their inferiority, does not seem to have reached the attention of the biologists. In fact, they are not concerned with such factors. Here Dr. Holmes quotes Dr. Saleeby's statement that those who survive are also injured—that "to talk of natural selection in anything so haz-

ardous and unnatural as a slum is widely unscientific"; that what really happens in the slum is "the damaging of all the life therein"—and mildly chides him for his impetuous and indignant protest. Nevertheless, his final sentence in this chapter is important: "A high infant death rate caused by agencies with an injurious effect on the germ plasm, instead of being a blessing in disguise, might prove to be an index of racial decay." With this sentence the reviewer is in hearty accord. Some day generations as yet unborn will say of our times: "This was a generation that knew how to fly in the air and dive under the waters, that had reached the stage where they could talk across aërial spaces and knew the marvels of serums and antitoxins, and yet this generation tolerated the slums."

A chapter on the selective influence of war is a comprehensive survey of the effects of war on the quality of the human being. It is pointed out that earlier warfares were probably eugenic in their influence whereas the later ones are dysgenic. He states that it is not improbable that most European wars have been injurious to all parties concerned in so far as the stock is concerned. How any one can doubt that, in view of the heavy mortality amongst the best physical and mental specimens, is a mystery to the reviewer.

Dr. Holmes then deals with selection, assortative mating, etc. Here again he becomes rather pessimistic as showing that the higher grades of individuals in the community are marrying late and having few children. One wonders, when reading about the superior peoples who marry late, whether or not their qualifications for superiority are not a bit artificial. They seem very selfish, quite cowardly, distinctly wedded to comfort and ease, and so they marry late and have few children. Their qualifications for superiority seem to rest entirely upon their achievements in the purely artificial fields of endeavor. Perhaps they lack fundamental instincts and are quite inferior.

The chapter on consanguineous marriages and mixed marriages is an interesting one, and you are given your choice of all kinds of opinions, especially in regard to mixed marriages. "Mixed marriages are horrible", says Shultz. "The mongrel is a degenerate"; and, on the other hand, say Rueter, Hoffman, Fisher, and Plossbartl: "Mixed marriages do no such thing and even produce superior people."

The chapter on alcohol and disease in their effects upon the hereditary structure of the human race is a well written and very comprehensive study. The author seems to be very well informed on the work done and has quoted almost the entire literature. To the reviewer's mind, this is the most important field of study in the whole

hereditary problem. The biological fetish that the germ plasm is somehow a thing set apart and uninfluenceable by environmental factors has paralyzed the thinking of our times along fruitful lines, but fortunately we are at a period when experiment is beginning to take the place of prejudice. The germ plasm is part of the body. The evolution of a primitive germ-plasm cell into the fully mature spermatozoön or ovum takes place within the body and is influenced by the state of nutrition, the condition of the blood, and the organic health of the individual taken as a whole. The fruitful study of heredity will attempt to discover what toxic substances hinder or deviate this development, and this is a study for clinical biologists or biological medical men.

This book is splendidly written and the subject matter is presented with great clearness and a sober, dispassionate impartiality that is admirable. Yet the author does not hesitate to express his own opinions wherever he has any. There is a remarkably good bibliography given at the end of each chapter. This bibliography alone makes the book invaluable to every one interested in racial problems, and especially the racial problems underlying health, mental and physical. Though varying from many of the attitudes taken by the author, the reviewer has no hesitation whatever in stating that every student of mental hygiene and every student of racial welfare should give this book a place of honor in his library.

Abraham Myerson.

Tufts Medical College.

Mind and Work; the Psychological Factors in Industry and Commerce. By Charles S. Myers, M.A., M.D. New York: G. P. Putnam's Sons, 1921. 175 p.

This interesting and useful book suffers from one main defect. Brevity, which is the soul of wit, is not the essential of exposition, and it seems to the reviewer that had Dr. Myers allowed himself more space, a brilliant contribution would have been the result.

The first chapter, which deals with the study of movement, is largely a restatement of the work of Gilbreth, and is a fine acknowledgment of the world's debt to the American industrial engineer.

Following this is his study of fatigue, and Myers lays great stress, and wisely, upon boredom and monotony as factors. The load the worker should carry, his posture, the illumination, ventilation, humidity, and temperature of the workroom are given space, but the writer also considers security against danger, length of hours, rest periods, etc. Vocational selection and guidance are discussed in general terms, which is perhaps all that can be done at the present time.

Restriction of output through deliberate act of the employee is analyzed, and the author cites cases where such restriction seems on the whole excusable in view of the unfair and selfish attitude of the employer. The danger and value of the bonus system are shown, and the relation between output and number of men on a job is considered. The chapter on the whole is characterized by a fair and exceedingly humane attitude.

The chapter on systems of payment is admirable in its restraint and clearness. The last chapter, which deals with the subject of industrial unrest, is largely a study in psychopathology.

The point of view of the dissatisfied employee is put with great fairness, and Myers rightly stresses the fact that the employee of the present day has been robbed of his right to a true vocation by the specialization of industry. He lays much emphasis on the necessity of allowing the worker to control by representation some part of his working conditions.

This study is on the whole dignified, clear, and impartial. It deserves to be included in the library of all persons interested in industry, as well as those not interested in industry who should be interested. Science, art, religion, and all the manifold activities of man are in the end based on the production and distribution of the commodities of the world.

The underlying problems of industry are not to be solved by the psychopathologists or psychologists alone, and the psychiatrists or psychologists who are presumptuous enough to claim this for their sciences in the end bring ridicule upon themselves. Furthermore, they delay the time when these two sciences will make their contribution to the study of industry, for it is true that psychiatry and psychology have discipline, data, and technique by which they can help in the solution of the intricate human problem that underly industry. Dr. Myers has certainly not claimed too much for the sciences he represents, and in that respect he might well be imitated by American psychiatrists.

Abraham Myerson.

Tufts Medical School.

Pasteur: the History of a Mind. By Émile Duclaux. Translated by Erwin F. Smith and Florence Hedges. Philadelphia: W. B. Saunders Company, 1920. 363 p.

Only now and then does a book such as this come from the press; it is of a kind all too rare. It is the sort of book one feels sure the author delighted in writing. While it was in process, there may have been many papers written under pressure, books and reports prepared

for an immediate purpose amid the daily routine and irritation. But always the author returned to this manuscript with delight, unhurried, with no immediate purpose in view. It is such a book as one turns over and over in one's mind, plans it and replans it, thinks and dreams of it, and says, "Some day I'll write it"—a book that before it is written is a part of one's self. Occasionally one of these books out of the richness of some one's living or experience gets written, and those of us who are so fortunate as to find it carry it home and cherish it.

These are seldom popular books. Usually they come from the press unheralded and are little known except to the few who almost by accident find them out. This particular book was published in France in 1896. Its author had been dead some three years when Erwin F. Smith, pathologist of the United States Department of Agriculture and the senior translator, discovered the title in a German catalogue of second-hand books. Ten years later—the book still undiscovered by the public—Smith begins his translation. Fifteen years after the death of its author the book becomes known to English readers.

The author, Émile Duclaux, was a student and assistant in Pasteur's laboratory. Upon the establishment of the Pasteur Institute in 1888, he was selected as administrator, and at the death of Pasteur in 1895 he was elected to succeed him as director. In his introduction Smith has given an interesting account of the life and work of Duclaux.

The book is more than a life of Pasteur. After Vallerey-Radot's classical *Life of Pasteur*, a biography was hardly needed. Duclaux's book is an absorbing account of one of the most fascinating periods in the history of science, the period when science was in a death grapple with the theory of spontaneous generation, a struggle less well known, perhaps, but as bitter and acrimonious as the conflict in England at almost the same time over evolution; the period when microscopic life now known by every schoolboy was first being suspected and then discovered and the foundations laid for our present knowledge of the part these organisms play in the economy of life. Every schoolgirl in a class in domestic science understands lactic and alcoholic fermentation—but what a mystery it was so recently as the 1850's, and what a conflict engaged the scientific world, and not alone the scientific, but the religious world, before it was over!

Through this conflict and the one over spontaneous generation, and those concerning diseases of wines and of silk worms, microbial diseases in animals and man, and finally those over viruses and vaccines, Duclaux takes us, building for each a brief, but vivid historical background. Against this background Pasteur is then shown at work; not so much Pasteur the man as Pasteur the scientist, his imagination,

his skill as an experimenter, his logic. The book is indeed the history of a mind, and a marvelous story it is as it unfolds.

The account of the development of Pasteur's ideas and the progress of his work are alone of great value, but there is much in the book besides; much that is of the wisdom of Duclaux. "This is a good illustration", he comments, after narrating the vicissitudes of Pasteur's contest with Pouchet, Joly, and Musset over the presence of germs in Maladetta air. "of what a series of judgments, revised without ceasing, goes to make up the incontestible progress of science. We must believe in the progress, but we must never accord more than a limited amount of confidence to the forms in which it is successively vested. One sometimes reaches the truth by error and sometimes error by truth."

The book is one to take on a vacation, not to be read through at a sitting, but to be picked up from time to time. It is richer in romance than a novel, fuller of courage and daring than a Western story. It is a book from which to gain inspiration and renewed confidence in the "incontestible progress of science". But one caution. Unless you are a physical chemist or a crystallographer, after reading the introduction pass to the second chapter.

Frankwood E. Williams.

The National Committee for Mental Hygiene.

Here and Now Story Book. By Lucy Sprague Mitchell. New York: E. P. Dutton and Company, 1921. 360 p.

This is a collection of short stories for children from two to seven years of age. It is claimed that these stories are psychologically correct, both as to content and form, and severe criticism is given to most of the children's stories of to-day. As a whole, the book is a useful addition to the small child's library.

The stories are prefaced by a seventy-two-page introduction in which the author discusses the theory of story telling to children. This merits careful reading by any one interested in the subject. According to the author, children's stories are to be thought of as having two components—content and form.

She claims that the content of stories for small children (two or three years old) should deal with familiar activities, with the things that make up their own world. The story must have plot, but no climax or sense of completion. A child thinks in motor terms, so the story should be in motor terms. "Stories, if they are to be a part of an educational process, must also further the growth of the sense of reality, must help the child to interpret the relationships in the world

around him and help him to develop a scientific process of thinking.'' This statement would indicate the importance of story books for small children in relation to the problem of mental hygiene, and the issue may well be raised whether the ordinary fairy tale does not have an exactly opposite effect. This point of view is advanced by the author, who holds that most fairy tales, myths, and sagas are to be condemned. Yet a lingering doubt remains. Is primitive man essentially a child, and if so, are not primitive myths and folklore things to be understood by the child and to appeal to him? The author further states: ''It is the peculiar function of a story to raise inquiries, not to give instruction. A story must stimulate, not merely inform.''

Having discussed the content of children's stories, she next takes up the form. She states: ''If content is but half, form is the other half of stories and not the easier half, either. Every story, to be worthy of the name, must have a pattern, a pattern which is both pleasing and comprehensible. This design, this composition, this pattern, whether it be of a story as a whole or of a sentence or a phrase, is as essential to a piece of writing as is the design or composition to a picture. It satisfies the emotional need of the child which is as essential in real education as is the intellectual. Without this design, language remains on the utilitarian level . . . where, to be sure, we usually find it in modern days.'' As to the type of pattern, the author maintains there are two fundamental principles: ''The individual units, whether ideas, sentences, or phrases, must be simple'', and ''These simple units must be put close together.''

A child attends to but one thing at a time, and his steps from one point to the next are short and clear. It is held that an enormous amount of repetition is relished by children of three or four years of age.

In analyzing the popularity of such books as *Mother Goose,* the author is of the opinion that it is the form and not the content that makes the enormous appeal to children. She believes that the real reason for giving stories to children is to get them to create their own.

The stories that follow in the book are patterned after those that children themselves have told, as the author feels that this is the correct guide to the ideal child story. The reviewer is not entirely convinced of this; most of us prefer stories written by some one of much greater ability than ourselves.

Karl M. Bowman.

Boston Psychopathic Hospital.

Man's Unconscious Spirit; The Psychoanalysis of Spiritism. By Wilfrid Lay, Ph.D. New York: Dodd, Mead, and Company, 1921. 337 p.

To use the author's own words, his thesis is "that the verbal utterances of mediums are but the fortuitous emergence into the medium's consciousness—or in some cases into the consciousness not of the medium, but of those who listen to him while he is in his trance—the emergence into consciousness of experiences which have for years or decades lain buried in the medium's own unconscious, and these utterances are not the result of telepathic communication from the living or from the spirits of the dead".

"Modern psychology is throwing more and more light on the unconscious and increasing the possibility of resuscitating in the individual memories which have lain dormant in him for years, and the results achieved show that there is in the content of the mediumistic messages a great similarity to that of the ordinary unconscious of the average man and woman."

Obviously, then, familiarity with the principles of the modern psychology, particularly psychoanalysis, is important for an understanding of spiritualism. The book is, therefore, written "to present as clearly as possible the complicated subject of the application of psychoanalytic facts to the claims made by the spiritists, and to indicate, for the help of those who instinctively feel that spiritism is a misinterpretation of facts, how the factors revealed by a knowledge of the unconscious bear upon the asseverations of the adherents of spiritism, and what regions of the normal human mind the spiritists have entered, without knowing it, and brought back from subliminal depths material that is not in any way extraordinary, nor valuable as a logical proof of the tacit assumptions of spiritism".

There is much interesting discussion of the application of the principles of psychoanalysis to spiritualism, most of which cannot be treated in a brief review. It may be pointed out, however, that the author at times emphasizes the emotion of fear as an element in determining spiritualistic interest. As he says in his introduction, "the energy expended by psychics and psychical researchers, in attempting to prove immortality and the various other phenomena, is a conscious desire prompted by an unconscious fear"; and again, (page 67) "The spiritist is one whose emotions are largely enlisted on the subject of death. He has, so to speak, a death complex . . . life, and by that I mean the continuance of conscious personality, will come more and more to be regarded as the greatest desideratum and death quite the opposite. Therefore, such a person will con-

sciously collect all possible evidence for the continuance of life and for the non-existence or the explaining away of death."

On the other hand, he says later (page 259): "The belief in disembodied spirits is the direct result of the unconscious death-wish on the part of the individual having this belief. . . . The wish for the death of some definite person, which is unconscious in the mind of the adult, was a conscious wish in the mind of the same adult when he was a child." He maintains that this infantile wish for the death of some person, particularly a near relative, is sadistic. He further maintains (page 261): "The way in which the sadistic death-wish tension is relaxed is through the compensatory wish for the continuance of the life of the person wished dead. . . . Hence the spirit world, which is the objectivation of the sadistic death-wish in the unconscious of the believer in spirits, and which is nothing else, having no foundation in absolute reality . . . the stronger the unconscious sadism, the profounder the belief and in some cases the more energetic the attempts to prove scientifically the existence of something that scientifically cannot even be conceived."

In the minds of some readers, the author perhaps might seem hardly consistent in the explanation of spiritualistic interest on the basis of fear of death and also as a compensation for the death-wish regarding some other person, and to these same minds the sadistic element in spiritualism might not be evident.

The author looks upon spiritualism as emotional and not scientific. "Science has to abandon all so-called certainty or knowledge not acquired by mathematical operations or laboratory experiments, and brand it neither certainty nor knowledge." (Page 244). And again (page 276): "The evidence of the senses is worthless for science." The author maintains that before spiritualism can be made scientific, there must be "the complete exclusion of the human element from all experimentation . . ." He implies throughout the book that the practice of psychoanalysis is scientific, but it is conceivable that the spiritists might argue that his assertions regarding the underlying motives in the spiritists were just as emotional as the spiritists' assertions about their investigations. As he himself says (page 256), "All statements, being the expression of judgments, are the verbal expression of the unconscious wish . . . we naturally say that something is so merely because we wish it were so (whether it is or not)." It would appear that the author would have a rather difficult time to prove that the psychoanalytic investigation of spiritualism was free from the human element and therefore scientific.

Clarence O. Cheney.

New York Psychiatric Institute.

American Association for the Study of the Feebleminded: Proceedings and Addresses of the Forty-fifth Annual Session, Held at Boston, Massachusetts, May 28, 29, 30, and 31, 1921. Benjamin W. Baker, M.D., Editor. Published by the Association, 1921. 150 p.

One of the oldest national medical associations in the country is the American Association for the Study of the Feebleminded. During the Centennial Exposition in Philadelphia in 1876, an invitation was extended to the "Superintendents of Institutions for Idiots and Feeble Minded Persons" by the Pennsylvania Training School at Media to meet for the purpose of organizing an association. On June 6 there were present Dr. E. Séguin of New York, Dr. H. B. Wilbur of Syracuse, Dr. G. A. Doren of Columbus, Ohio, Dr. C. T. Wilbur of Jacksonville, Illinois, Dr. H. M. Knight of Lakeville, Connecticut, and Dr. I. N. Kerlin of Media. At this meeting an organization was formed and designated the "Association of Medical Officers of the American Institution for Idiotic and Feeble Minded Persons" and the following officers elected: President, Dr. E. Séguin; Vice-president, Dr. H. B. Wilbur; Secretary and Treasurer, Dr. I. N. Kerlin. No papers were read at this first meeting. The second meeting was held in 1877 at the Ohio State Asylum for the Education of Idiotic and Imbecile Youth, Columbus. The following papers were read at this session: *A Typical Case of Sensorial Idiocy* by Dr. E. Séguin; *The Organization of Establishments for the Idiotic and Imbecile Classes* by Dr. I. N. Kerlin; *Prevention of Mental Diseases* by Mrs. C. W. Brown of Barre, Massachusetts; and *Classification of Idiocy* by Dr. H. B. Wilbur.

The association, which later changed its name to the American Association for the Study of the Feebleminded, has continued its meetings since 1876, and its annual published proceedings form an invaluable record of the development of the care of the feebleminded in this country and the studies, both clinical and social, that have been made in the past forty-six years. The early proceedings were published by the J. B. Lippincott Company of Philadelphia. For a number of years the proceedings were published as the *Journal of Psycho-asthenics,* edited by the late Dr. A. C. Rogers of Faribault, Minnesota. The proceedings for the Forty-fifth Session returns to the earlier and more usual form of such publications. The present volume is attractively printed and has been ably edited by Dr. Baker, secretary of the association. Among the papers thus made available are the following: *Colony Care for Isolation Defective and Dependent Cases,* Dr. Charles Bernstein, Superintendent, Rome State School, Rome, New York; *One Hundred Institutionally Trained Male*

Defectives in the Community under Supervision, Mabel A. Matthews, Head Social Worker, Massachusetts School for Feebleminded, Waverley; *Extra-Institutional Care of Mental Defectives*, Dr. E. W. Fuller, Senior Assistant Physician, Rome State School, Rome, New York; *A Clinical Demonstration of Endocrine Symptoms in the Feebleminded*, Dr. Walter Timme, New York City; *Massachusetts Methods of Dealing with the Defective Delinquent*, Hon. Herbert C. Parsons, Trustee of Wrentham State School and Commissioner of Probation for Massachusetts; *The Parole System at the Wrentham State School*, Johanna D. Lillyman, Head Social Worker, Wrentham State School; *The Methods and Uses of Group Testing of Intelligence*, Professor Walter E. Dearborn, Psycho-Educational Clinic, Harvard University; *The Scientific Recognition of Characterial Organizations in Psychiatry to the Feebleminded*, Dr. Guy G. Fernald, Medical Director, Massachusetts Reformatory, Concord.

It is understood that there are available at the present time a few complete sets of the proceedings of this association. As an historical record alone, these have very great value, and libraries, as well as institutions, will, no doubt, be glad to know that they are available.

HARLEY A. HAYNES.

The National Committee for Mental Hygiene.

THE ESSENTIALS OF MENTAL MEASUREMENT. By William Brown and Godfrey H. Thomson. Cambridge: Cambridge University Press, 1921. 216 p.

This book gives a technical account of the mathematical theories of mental measurement, with some rather happy popular illustrations of the points it wishes to convey. It will be of interest to the student of psychology who is seeking a more perfect method of measuring and correlating his data, not to the beginner.

The first part is called *Psycho-physics*, and describes several psychophysical methods, together with means, not only of measuring, but of determining the reliability of material collected by them.

Part 2, *Correlation*, after going into great mathematical detail in deducing the various formulæ for correlation coefficients, takes up Spearman's theory of general ability. Spearman came to his conclusion because the coefficients of correlation between a number of mental tests and school grades arranged themselves in a hierarchical order. That is, in a given group, "a" ability will correlate highly with "b" and "c", less highly with "d" and "e", and not at all with "f". This would seem to indicate that there is a general factor at the basis of all these special abilities.

Thomson replies by showing, with dice and playing cards, that this hierarchical order is inherent in the correlation coefficients, not in the individual. In the second place, the failure in practically all experiments on transfer of training, of practice in one skill to make one more efficient in another, indicates that abilities are special, and not general. "As an alternative theory, Thomson has advanced a sampling theory of ability in which any performance is considered as being carried out by a sample of group factors. This theory is preferred because it is more elastic and wider, and because it is in closer accord with theories in use in biology and in the study of heredity."

DONALD SLESINGER.

The National Committee for Mental Hygiene.

FIELD WORK AND SOCIAL RESEARCH. By F. Stuart Chapin, Ph.D., Professor of Sociology, Smith College. New York: Century Company, 1920. 224 p.

Sociology, long a vague and hybrid body of knowledge, despised by students of older and more exact disciplines, is in process of becoming a science. Some may see in it neither data nor method for such a claim. This book should enlighten them. It is a critical study of the tools that are available to the worker in social research. We can do no better than quote the following table in which Chapin analyzes the inductive method and its correlative steps in social research:

The inductive method	*Methods of social research*
1. The working hypothesis.	1. The historical method of critically using documentary sources (indirect observation).
2. Collecting and recording of facts of observation.	2. Field work. Observation by first-hand contact with the facts (direct observation). a. Case-work. b. Sampling. c. Complete enumeration.
3. Classification of the facts of observation into series and sequences for comparison.	3. The statistical method. a. Tabulation. b. Graphs, ratios, averages, indexes, correlation coefficients, etc.
4. Generalization from these classified facts to some short formula or law which explains their relations.	

As the title implies, the author concentrates on the second of the three methods of social research listed—namely, field work, with its threefold division into case-work, sampling, and complete enumera-

tion, according as the data to be dealt with are derived from the individual, the partial group, or the entire community. He does devote a chapter to the examination of sources (indirect observation by the critical use of historical documents) and one to editing and tabulating the data secured from field work. But he wisely omits from the scope of the book a consideration of statistical method, upon which there are available numerous competent and exhaustive works.

As types of field work scientifically planned and executed, Chapin devotes some space to the investigations of the United States Commission on Industrial Relations and those of the Health Insurance Commission of the State of Illinois into the health and standards of living of wage-earning families in Chicago, and to the classical infant-mortality studies of the Federal Children's Bureau.

The case-work chapter is practically a summary of Miss Richmond's well-known *Social Diagnosis*, and uses as examples of medico-social case technique Dr. William Healy's outline for the diagnosis of the individual delinquent and Dr. Hibbert W. Hill's epidemiological procedures for determining the origin of a typhoid outbreak.

The "partial canvass" or "representative sample" resolves itself largely into the method generally known as the social survey. The familiar illustrations used, chiefly from surveys made by the Russell Sage Foundation, include Pittsburgh, Syracuse, and Springfield (Illinois). From the Children's Bureau studies and those of Miss Byington and Arthur Bowley, the author shows the nature and method of obtaining a representative sample.

The government census is of course the logical representation of complete enumeration. The Massachusetts State Census of 1915 offers thorough technique here.

The utility of this handbook for mental hygienists lies not in any direct application to psychiatric problems. Healy's work and that of the Eugenics Record Office are the only references to the field. But all investigators have occasion at times to prepare a schedule or a questionnaire and want to know what to include and the best way of phrasing it. Every one must at times construct a table, examine an official report for source material, or determine how many cases he must have to secure a valid and significant conclusion. The answers to such questions as these are based on universal principles, and Dr. Chapin has done us all a valuable service in bringing together for the first time in convenient form the generalizations upon which sound field work must be founded.

KENNETH M. GOULD.

American Public Health Association.

Shackled Youth. By Edward Yeomans. Boston: The Atlantic Monthly Press, 1921. 138 p.

This very interesting and stimulating little book deserves much attention. The publication of the original articles in the *Atlantic Monthly* produced much discussion and favorable comment, for the subject matter, as presented by the author, contains many very worthwhile suggestions that might well be incorporated in present-day educational programs.

The attitude of the author, as described in his first chapter concerning "a point of view on schools in general", is courageous and should receive hearty acclaim among those of us who are primarily interested in the successful and happy educational and social adjustments of children.

The contents of the succeeding chapters on geography, history, music, literature in the grades, and natural history contain many valuable points worthy of the consideration of all educators, if their preconceived goal for educational success permits the inclusion of real, vital human interests, although in his text the author would seem to view the dogmatism and inelasticity of the educators through pessimistic eyes. Moreover, his discouragement, as reflected in his discussion of the broader educational problems, includes the larger social group, the community, as well, for he says, "Whole communities share an infatuation that their school is good for children simply because the children do not resent it."

If the children themselves knew of the intriguing possibilities of a school shop such as the one described by Mr. Yeomans, one might predict a movement from within the school body politic itself. But it is gratifying to discover progress toward a newer, broader education, such as Edward Yeomans, Joseph K. Hart, and some of the other forward-looking, socially minded people of the day are making through the avenues of the printed page. It is our belief that through their efforts many followers may be gained, and out of this organization of public opinion may come the needed impetus for a new educational system. Books of this kind deserve wide distribution in order that the reading public may be assisted in recrystallizing their ideas concerning the educational needs of the school child.

Marion E. Kenworthy.
Bureau of Children's Guidance, New York City.

The Soul of a Child. By Edwin Björkman. New York: Alfred A. Knopf, 1922. 322 p.

A "good" home, a "loving" mother, a "dutiful" father, a "good" school with "capable" instructors, and, on the whole, "good" com-

panions, and yet a boy who has had all these "advantages" and who at five and during the early years of his school life was bright and alert so that he took the chief annual prize at his school, was happy and quesitive, lovable and friendly, at fifteen is surly, rebellious, indifferent, and "lazy". His ambition to go to college is lost and he leaves school in disgust to become a clerk. Was this inevitable? Was it merely that the early promise was a false one and that the boy had no real capacity? Was it not, after all, the boy's fault that he got all crossways with things? There are, at any rate, so many children who metamorphose in this way that one is probably justified in assuming that it is inevitable and that such children are born to fail.

But the "good" home—it was a middle-class Swedish home that the citizens of Stockholm no doubt considered good, that the pastor would think was good, and that probably most social workers would put down as good—contained a "loving" mother, whose neuroticism tyrannized the boy, and a "dutiful" father, who was now hard, now soft, so that the boy was now confused, now embarrassed, before him. With the best intentions in the world, these parents give the boy to drink of the bitter brew of their own unhappiness and defeat, their tempers, their querulousness, their pretense, their disingenuousness, their deception. The father demands that the boy be "honest" and then appropriates the money he has won as a prize at school. The mother importunes him to keep himself "clean and pure", and he wonders what it is all about—not because he doesn't know some things, but because he doesn't see any connection between what he learned behind the big rock on the farm and being "clean and pure"; but he begins vaguely to wonder.

School and books are a relief for a time, but the "capable" instructors soon begin to draw in the straps of the strait-jacket, and the father disapproves of borrowing books as they might be lost or injured and he would then have to pay for them. Bit by bit, here and there, the boy gathers information and misinformation about sex. Eventually a book comes into his hand—"he read as he had never read before in his brief span of life". "Pages were consumed before he realized with a shock more intense than any one previously experienced that the book was speaking of the game he learned to play back of the big rock. . . . He learned that physically and spiritually he had courted death, and what is worse than death. . . . Worse than any thought of punishment . . . was the book's damning imputation of shame incurred, of unworthiness, of inferiority so deep that no words could adequately picture it. . . . The game learned behind the big rock must not be played again—that much was certain.

But all resolves proved vain. Fight as he may, the end was inevitably the same. . . . His life was an unending conflict, and in the presence of that ever-renewed struggle within, by forces that seemed alien to his own self, all else lost significance. And there was not a thing or a person within reach that could offer an antidote to the self-contempt corroding his soul's integrity.

"Going to school grew very hard for a while. He could barely look his schoolmates in the face for fear that they might read in his eyes what sort of a chap he was. At times, on his walks to or from school with Murray, a faintness would seize him at the mere thought that his friend somehow might have guessed the truth. And he sent timidly envious side glances at one lucky enough to be raised above all temptation. For neither his recollections of the gang gathered about the big rock nor the more recent light shed on such things by Johan had the slightest influence on his conception of himself as the sole black sheep in a flock of perhaps soiled, but nevertheless washable white ones.

"After a while the poignancy of his emotions became blunted by familiarity, and mere weariness forced him to accept himself on a reduced level. A sort of new equilibrium was established within him, but it was primarily based on indifference. Nothing really mattered. Effort was useless. Things merely happened. No one else could help what happened. And in this fatalism, so utterly foreign to his ardent, supersensitive nature, he found a certain momentary sense of peace."

Keith Wellander is a boy in a book and would be unimportant except for the fact that Björkman, in giving this intimate account of the emotional development of Keith has given an account of the emotional development of many a boy. And is the result foreordained and inevitable? One feels justified in believing that the sullen, disgruntled, "lazy" boy of fifteen was made, not born.

There is nothing in the story of Keith Wellander that has not been pointed out many times in this and other journals, but this book, put out in popular form, will no doubt be read by thousands of parents who never heard of MENTAL HYGIENE. One wishes for it, therefore, a very large circulation.

FRANKWOOD E. WILLIAMS.

The National Committee for Mental Hygiene.

HUMAN TRAITS AND THEIR SOCIAL SIGNIFICANCE. By Irwin Edmond, Ph.D. Boston: Houghton Mifflin Company, 1920. 467 p.

The author of this book states in his foreword that it was written originally and primarily for use in a course entitled *Introduction to Contemporary Civilization*, and that it is an attempt to give a bird's-

eye view of the processes of human nature from simple inborn impulses and needs to the most complete fulfilment of these in the deliberate activities of religion, art, science, and morals. He also states his hope that the book may give to the student and general reader a knowledge of the fundamentals of human nature and a sense of the possibilities these offer and the limits they set to human enterprise. As the writer of a textbook, we think that the author has failed to achieve his purpose; he has ignored that with which he must be fully acquainted—namely, that a textbook should state its principles with an unusual degree of clearness and definiteness. While brevity is not always a desirable thing, yet a principle briefly stated is more easily grasped by a student than a principle clothed in a mass of words.

The book is divided into two parts. In part one, the author deals with such traits as are manifest in the human individual and necessary for his social adaptation. He attempts an analysis of these traits with the idea of demonstrating their value in art, religion, science, and morals, which are the topics discussed in part two under the title *The Career of Reason.* It seems, however, that he is laboring under a misapprehension as to the meaning of various traits, amongst which is the trait "self", under which is discussed personality. Dual personality has a distinct place in psychology and must not be confused with the variation of the individual's reaction in various environments.

Throughout the volume similar criticisms can be made in reference to individual human instincts as here described. Whereas the book is a contribution to psychological literature and as such has a bearing on art, religion, science, and morals, yet the query may be raised whether it is not more worthy of a space in the teacher's library than in the student's.

FREDERIC J. FARNELL.

Rhode Island Society for Mental Hygiene.

WHEN CHILDREN ERR; A BOOK FOR YOUNG MOTHERS. By Elizabeth Harrison. Chicago: The National Kindergarten College. 177 p.

MISUNDERSTOOD CHILDREN; SKETCHES TAKEN FROM LIFE. By Elizabeth Harrison. New York: The Macmillan Company, 1922. 168 p.

These two little books are written by a loyal disciple of Froebel and are filled with illustrations taken from an extended kindergarten experience.

Many fundamentally valuable hints are given in the section devoted to discipline in *When Children Err.* The author pleads that the child be treated as a rational being and that "as soon as he is able to

reason", he be led to feel that there are laws of right and wrong which do not depend upon any mere individual view. To "universalize the deed", she would ask the misbehaving child "what would happen *if all children in like circumstances were permitted to do this same thing*".

"Educative punishments" are discussed in some detail. This method is designed to "educate the child's emotions and will, as well as his intellectual assent"—in other words, it lets "the deed bring its own results as nearly as possible and with as little interference from us as our lust for power will permit". In connection with this method, the giving of prizes as rewards for well doing is strongly condemned, not only because it gives "physical gratification for a spiritual struggle", but also because it "confuses the child's idea of the nature of his deed".

Corporal punishments, the author believes, result in general from an excessive consciousness of authority on the part of the parent and an underestimate of the rights of the child, or from an inability to see the child's point of view. Her statement "corporal punishment should be looked upon as the least valuable form of punishment and only to be administered when better plans fail" is somewhat confusing, as one at once wonders whether from a pragmatic standpoint one should consider a failing plan better than one that may succeed in teaching children the need for respecting authority, which the author agrees is a necessary part of the child's training.

There is no doubt, however, that the author is a firm believer in individualized treatment and in never-failing justice, both important elements in discipline.

Misunderstood Children consists of a series of sketches taken from life designed to illustrate mistakes to be avoided in dealing with children. It is written with so much sentimental detail that one sympathizes with the little girl's remark, "Mother, I think I could understand better if you did not explain so much." For the intelligent reader, the "foreword" is the best part of the book.

Anne T. Bingham.

New York Probation and Protective Association.

A Psychoanalytic Study of Psychoses with Endocrinoses. By Dudley Ward Fay, Ph.D. (Nervous and Mental Disease Monograph Series, No. 33.) New York: Nervous and Mental Disease Publishing Company, 1922. 122 p.

As stated in the introduction, this thesis is a psychoanalytic study of twenty-two male patients in an experiment on psychoses associated with recognized endocrine disorders, conducted at St. Elizabeths

Hospital, Washington, D. C., by Dr. Nolan and Dr. Lewis, with the assistance of Dr. Gertrude Davies and the author. The object was to discover whether there is any correlation between certain endocrine disorders and certain psychotic syndromes, and to learn what sort of mental disturbance is associated with a disorder of each particular gland or combination of glands.

The twenty-two men studied were selected from the patients of the hospital and were placed for six months on a sunny ward with the resources of occupational therapy and recreational activities. An analytic study of each case was made during the period of the experiment while glandular therapy was being administered. After six months' observation the group was disbanded and the patients returned to the other hospital wards. Four months later they were again examined by the author and their conditions noted.

The endocrine diagnoses included submyxedema (13), hypoadrenia (2), hyperthyroidism (4), hyperthyroidism with dyspituitarism (1), hypothyroidism with infantilism (1), and dyspituitarism (1). According to the mental diagnoses, every case was schizophrenia or had schizophrenic features.

Of the twenty-two cases studied, eight showed improvement during the period of observation. In two of the cases the improvement was thought to be due to the occupational therapy, which also contributed to the general happiness of the group and served as a valuable indicator of the patients' conditions.

Some of the cases were too deteriorated to benefit from psychoanalytic treatment. Some were too negativistic and resistant, while others were either too inattentive or too disturbed to receive help from such procedure. The author believes that in but one of the cases treated did any benefit result from the analytic treatment, although he states that other patients studied in the same hospital have shown more favorable results.

The early results of the glandular therapy were strikingly encouraging, but the improvement gradually faded as the treatment proceeded. In four of the cases, however, the patients' conditions were distinctly improved by it, the benefit lasting while under observation. No definite correlation was found between glandular conditions and mental states, although the hyperthyroid cases as a whole seemed to be more extraverted and to keep in closer contact with reality than the other types, while the feeding of desiccated thyroid gland seemed to reduce introversion and to cause the patient to come into closer contact with his environment.

From a psychoanalytic standpoint, the case histories are exceedingly interesting studies. From a glandular standpoint, however, the thesis is disappointing, not because of the negative findings in both

the relationship between mental and glandular symptoms and in the therapeutic results, but because so few endocrinologic data are furnished. Tests were apparently made that were not recorded in the physical findings. Not only is it hard in some cases to find sufficient foundation for the diagnosis made, but at times characteristics are described that suggest the involvement of other glands besides the one mentioned. For this reason, the study of the correlation between the endocrine disorder and the psychotic syndrome, which constitutes one purpose of the thesis, has not the interest for students that it otherwise would have.

The author reviews the literature on the subject of the relation between glands and mental states, showing the great variability in the observations of different experimenters. It is to be hoped that this study, with its interesting and valuable psychoanalytic interpretations, will be followed by others of a similar nature in which the endocrine phase will be given greater emphasis.

Edith R. Spaulding.
Out-patient Department, St. Luke's Hospital, New York.

The Psychology of Thought and Feeling. By Charles Platt, B.S., Ph.D., M.D., F.C.S. New York: Dodd, Mead, and Company, 1921. 282 p.

From the author's preface, the reader is led to anticipate that this book holds much material worthy of the attention of those interested in exploring the fields of psychology.

The first third of the book contains an interesting discussion of the fundamental concepts of inherited dispositions and subject matter pertaining to "compound emotions". To those familiar with the classical production of McDougall, the statements here set forth have unmistakable earmarks of McDougall's earlier contribution.

As the reader progresses through the remaining chapters of the book, dealing with the subjects of education, the subconscious mind, mental ills, the crowd, the delinquent, etc., he is inclined to wish that other books containing well organized concepts of these particular subjects might have been utilized in the preparation of this contribution to the psychology of thought and feeling, for the material as presented lacks evidence of organization, and at many points the reader is left entirely at sea as to the real purpose of the production.

In the discussion of "thought and judgment", although one might justly suppose that the author has sufficient understanding of the fundamentals of the newer psychology to enable him to discuss the psychological aspects of these subjects, he contents himself with giving descriptions of complexes, with a discussion of the processes of

rationalization of this affective material, failing thereby to contribute materially to the reader's general concept of the newer psychological implications.

In the chapter on "mental ills", the author displays a surprising paucity of information concerning some of the psychotic entities. For example, in his discussion of alcoholic indulgence, he says: "Prolonged alcoholism must naturally incline toward lowered vitality in offspring, but it does not give rise to insanity—unless the delirium of the patient in acute alcoholism be so counted." A statement like this could be made only by some one unfamiliar with the disease entities known as chronic alcoholic hallucinosis and alcoholic dementia found in actual clinical experience.

Altogether, the book is disappointing; it contains nothing new, and the lack of coördination and unity of the material included leaves much to be desired.

Marion E. Kenworthy.

Bureau of Children's Guidance, New York.

Aspects of Child Life and Education. By G. Stanley Hall, LL.D., and some of his pupils. New York: D. Appleton and Company, 1921. 326 p.

President Hall has gathered into this book nine papers, all but one of which have been previously published. Three of the papers are by President Hall—*The Contents of Children's Minds,* originally printed in 1883; *The Story of a Sand Pile;* and *Boy Life in a Massachusetts Country Town Forty Years Ago.* Two are papers written by students in conjunction with President Hall—*Curiosity and Interest* by Theodate L. Smith and *A Study of Dolls* by A. Caswell Ellis. Four are by students—*The Psychology of Dreams* by Theodate L. Smith; *The Collecting Instinct* by Caroline Frear Burk; *The Psychology of Ownership* by Linus W. Kline and C. J. France; and *Fetichism in Children* by G. Harold Ellis.

These papers have been selected from something over a hundred papers written in the past thirty years by students at Clark University who, by the questionnaire method, have been studying special aspects of child life, such as the child's relation to nature (experience with light and darkness, day and night, etc.); development of the sense of self; some of the fundamental activities of the child (pleasure, pain, fears, etc.); social impulses (the gang, rudimentary society among boys, etc.); juvenile manifestations of fun, wit, humor, and the like. In his preface President Hall states that "studies like those in this volume might be called researches into the archæology of the human soul," and expresses the hope that it may be possible

in the future to gather certain of these studies in volumes on one or more of the above groups.

A good deal of water has gone over the psychological mill in the last seventeen years since the most recent of the papers in this volume was originally published, so that it is not surprising, perhaps, that the book would seem to contain no new data in regard to the psychology of childhood.

FRANKWOOD E. WILLIAMS.
The National Committee for Mental Hygiene.

THE HABIT OF HEALTH. By Oliver Huckel. New York: Thomas Y. Crowell Company, 1922. 128 p.

THE ART OF THINKING. By T. Sharper Knowlson. New York: Thomas Y. Crowell Company, 1922. 165 p.

PRACTICAL SELF-HELP. By Christian D. Larson. New York: Thomas Y. Crowell Company, 1922. 223 p.

The little book, *The Habit of Health,* contains nine short chapters in which the author attempts to correlate the spiritual with the psychopathological.

In *The Art of Thinking,* the author has hastily referred to a few facts in relation to thinking and then suggested to the reader that he indulge in the works of various other writers.

In *Practical Self-Help,* the author has attempted to present the knowledge of doing things in an approach to helping oneself. There is much repetition and reiteration and a rather meager comment upon how to do many of these things.

These three books are superficial presentations of their respective subjects, but nevertheless will undoubtedly fulfill the purpose for which they were written.

FREDERIC J. FARNELL.
Rhode Island Society for Mental Hygiene.

A YOUNG GIRL'S DIARY. Prefaced with a letter by Sigmund Freud. New York: Thomas Seltzer, 1921. 284 p.

Much has been said of the rôle played by the instincts during the period of childhood and adolescence, but not until the publication of *A Young Girl's Diary* have we had in concrete form such a clear and graphic account of a young girl's responses to the intimate personal contacts experienced by her in her home, school, and play.

The facts recorded cover a period of four and one-half years, between the ages of eleven and fourteen, and the material contained in the text furnishes the reader with a first-hand glimpse into the soul of this adolescent child. As the pages unfold themselves, it is possible to trace the outcroppings of the unconscious instinctive elements that

tend to influence the development of the personality of this growing child.

The description of the varied types and phases of her affective responses to the stimuli both from within herself and those arising through the medium of her environmental setting should furnish data of real interest to students of human behavior who are striving to gain a clearer and more complete understanding of the dynamic elements in the life of a growing child.

Documents of this type, containing a careful, painstaking record of each day's affective experiences during the adolescent phase of normal childhood, should enrich our understanding of the psychology of human behavior, and it is to be hoped that other books of the same value may be forthcoming.

MARION E. KENWORTHY.

Bureau of Children's Guidance, New York.

REPORT OF DIVISION OF EDUCATIONAL TESTS FOR 1919-1920. By Walter S. Monroe. Urbana: University of Illinois, 1921. (Bureau of Educational Research Bulletin No. 5.) 64 p.

This monograph deals with the standardization of educational tests. These tests are devised to measure the child's mastery of the various studies in the school curriculum. They are standardized for the various grades. Such tests can be made to take the place of the ordinary examinations and they are especially good in sorting out the children into groups—superior, average, and inferior.

In standardizing the tests, data were obtained from fourteen cities—nine in Kansas and one in each of the following states: Illinois, Ohio, Michigan, New York, and Pennsylvania. Some of these were large cities and some medium-sized cities. It will be seen that this was largely Mid-Western distribution and that for greater accuracy it would be well to use the tests in a group of Eastern and extreme-Western cities.

The author uses not averages, but median scores, twenty-five and seventy-five percentiles being used. This is much more accurate than averages and is much better for the establishment of norms than is the average score.

The tests were given from September to June in any single school year. This may be a more satisfactory method of administration. In general it is desirable, possibly, to have the tests given at a fixed time in the year, as the standard for the beginning, the mid-year, and the end of the year are seen to vary quite remarkably. It is preferable, therefore, to have graded tests given at stated periods and with more uniformity. It gives a greater usefulness to the standard obtained.

It is easier for teachers who are comparing standards of their classes with other classes to compare scores with the beginning, the middle, or the end of the school year, than to search for the particular month under which similar tests were given and compare with the score in question.

In the tables for arithmetic, the tests show scores for:

1. Correct use of principles in solution
2. Rate, speed of performance
3. Correct answers found

For silent reading tests the Monroe tests were used. Here the rate of reading, the comprehension of material read, and the reading-ability score were found.

In our clinic here at the University of Wisconsin, we have been using certain reading tests devised by Starch. The method differs so much, however, that it is impossible to compare with Monroe's results the results found here.

The author admits that the use of weighted scores does not give much more accuracy than when scores are used without the weighting system. This weighting of scores is quite complicated and most teachers do not understand the method employed; nor can they easily use scores found by the weighting system. We believe, then, that it is best, if such scores are to be used by the average teacher, not to use the weighting system of obtaining scores.

The Monroe Timed Sentence spelling test aims to measure ability in spelling. This is a much more accurate measure of the pupil's ability in spelling than the ordinary spelling test, because the words are not given an unnatural setting, as in the old-fashioned spelling book, but are arranged in sentences so that the test word is not prominent and the attention is not especially forced on one particular word. Instead, a series is presented and the attention is therefore distributed over a series of words, as is a natural thing in ordinary spelling.

Such tests have a very definite value. It must be borne in mind, however, that many children fail to come up to the standard, even though the tests are properly standardized, because of various emotional and physical difficulties. Therefore, group testing should always be followed by the individual study of those children who fall markedly below the group.

This is a very interesting and helpful monograph for school authorities whose duty it is to organize and modify the curriculum in the public school so as to adjust the various studies to the pupils' needs, grade by grade.

SMILEY BLANTON.

University of Wisconsin.

NOTES AND COMMENTS

Alabama

The United States Public Health Service Hospital at Tuskegee, Alabama, has received an appropriation of $2,500,000. There will be 230 beds for tuberculous patients and 270 beds for mental and nervous patients. In addition, an administration building and a recreation building are planned.

Florida

The 1921 appropriation act allows the Florida State Hospital, for purposes other than maintenance, the sum of $128,800. By this law the new Farm Colony for Epileptic and Feebleminded receives $125,000 for specified improvements and $150,000 for maintenance.

Idaho

The last legislative assembly enacted a law providing for the deportation of non-residents adjudged to be insane or feebleminded within the state. This act also imposes a fine as the penalty for transporting into the state any idiot, imbecile or insane person.

Massachusetts

A division of mental hygiene in the department of mental diseases is created by Chapter 519, Laws of 1922. This act is particularly worthy of mention, as it authorizes the division to institute inquiries into the causes of mental disease, epilepsy and feeblemindedness, with a view to prevention. One section of the law reads as follows:

"The department shall take cognizance of all matters affecting the mental health of the citizens of the commonwealth, and shall make investigations and inquiries relative to all causes and conditions that tend to jeopardize said health, and the causes of mental disease, feeblemindedness and epilepsy, and the effects of employments, conditions and circumstances on mental health, including the effect thereon of the use of drugs, liquors and stimulants. It shall collect and disseminate such information relating thereto as it considers proper for diffusion among the people, and shall define what physical ailments, habits and conditions surrounding employment are to be deemed dangerous to mental health."

The new Belchertown State School is expected to open formally for the reception of patients this summer. By Chapter 410, Laws of 1922, all acts in force with reference to the care of the feebleminded at other state institutions are made applicable to this institution.

Chapter 467, Laws of 1922, authorizes the commissioner of mental diseases to negotiate with the trustees of Smith College for the sale to the latter of about thirty acres of land at the Northampton State Hospital. The proceeds from this sale may be used for the purchase of additional land in Northampton.

The report of the special commission, created in 1921 to investigate the matter of providing suitable quarters for defective delinquents, recommending the use of that part of the State Farm at Bridgewater formerly used for alcoholics has been accepted. The governor has proclaimed the establishment of a department for defective delinquents. The State Farm has already received a few such patients. Notices to the courts request that only male offenders between the ages of 17 and 25 be sent to this institution because of limited facilities.

Missouri

A new building to accommodate 120 patients will be constructed at State Hospital No. 1, Fulton, at a cost of $85,000.

Bellefontaine Farm is the name of St. Louis' new municipal farm for mental defectives. It contains nearly 500 acres of land about three miles from the city.

Nevada

Chapter 149, Laws of 1921, provides for the care of ex-service men suffering from mental disease in specially equipped quarters at the Nevada Hospital for Mental Diseases, Reno. Four thousand dollars is appropriated for necessary repairs, employment of nurses, and carrying out the provisions of this act.

A legitimate child may be adopted without the consent of its parents when the father or mother has been declared either incurably feebleminded or insane by a court of competent jurisdiction. This amendment is made by Chapter 216, Laws of 1921.

New York

Dr. Sanger Brown, 2d, has been appointed chairman of the state commission for mental defectives to fill the vacancy caused by the death of Dr. Pearce Bailey.

North Carolina

Several new buildings, including dormitories and a dining hall, have been completed at the Caswell Training School.

Ohio

Eighteen additional cottages are planned for the new Institution for Feebleminded at Orient, authorized in 1919. The total appropriations, including the purchase of 112 acres of land, buildings, repairs, and equipment, are $357,000 for the biennium ending June 30, 1923. The original act creating this institution carried an appropriation of $650,000.

Oklahoma

The sum of $150,000 has been appropriated for a new ward building at the Eastern Oklahoma Hospital, Vinita. At the Western Oklahoma Hospital, Supply, $200,000 is to be expended over a period of two years for two ward buildings. Three thousand dollars a year for the care of tubercuIous patients is included in the 1921 appropriations for this hospital.

Pennsylvania

A new infirmary of 120 beds is to be added at the Philadelphia Hospital for Mental Diseases.

Vermont

Four new buildings are to be constructed at the state hospital for mental diseases—a women's dormitory, a men's dormitory, a service building, and a reception building.

Virginia

A commission on mental health is authorized by Chapter 368, Laws of 1922. Its membership is to be as follows: chairman of the state board of public welfare, commissioner of that board, one member of the state senate, one member of the house of delegates, commissioner of state hospitals, superintendent of Central State Hospital, superintendent of Colony for Epilepties and Feebleminded, state health commissioner, superintendent of public instruction, and two citizens from the state at large. The purpose of the commission is to inquire into the several matters stated in the preamble to the act, and to make a report with recommendations to be included in the 1923 annual report of the board of public welfare. The preamble is as follows:

"Whereas, there is need for more general dissemination of information and wider public interest regarding mental hygiene, the prevalence, causes and prevention of insanity, mental defect and epilepsy and their effects on the individual, his or her offspring, the community and the state; and,

"Whereas, inadequate special provision is now made in our public schools for the appropriate teaching and training of mentally deficient, backward and epileptic children; and,

"Whereas, insufficient consideration and study are given to the relationship of mental disorders and epilepsy to crime and moral delinquency; and,

"Whereas, defective delinquents constitute a troublesome group in our hospitals, prisons, reformatories and industrial schools, that need special study and custody, and probably a separate institution; and,

"Whereas, many mental defectives and epileptics that cannot be provided for in our state institutions need better supervision and care than can be given them in their homes; and,

"Whereas, out-patient mental clinics and hospital social service have seemed to have proven of advantage elsewhere; and,

"Whereas, special provision for border-line or doubtful cases, and the diagnosis and study of mental diseases in their incipiency and most curable stage should receive more attention, thereby aiding in earlier recovery; and,

"Whereas, a psychopathic hospital and institute seem to furnish the best means of such diagnosis and treatment, and the scientific study and research into abnormal and subnormal mental conditions and the clinical teaching of psychiatry; and,

"Whereas, many patients furloughed or discharged from the several state institutions for the insane, feebleminded and epileptic frequently need advice and assistance of psychiatrists and trained social workers, in order that such cases may more readily readjust themselves to their environment, avoid social and economic stress, and procure suitable employment and home care and treatment, thereby preventing another mental upset; therefore, be it enacted . . . ."

The Central State Hospital at Petersburg has purchased an adjoining farm of nearly one hundred acres which will probably be used for the feebleminded. The establishment of a colony for feebleminded and a colony for colored epileptics has been authorized at this institution.

The Virginia Epileptic Colony has received an appropriation of $42,500 for a new dormitory for fifty women.

West Virginia

A new building for the diagnosis and treatment of ex-service men has been opened at the Huntington State Hospital. It will accommodate fifty patients.

Canada

Construction has begun on a new unit of the Public Hospital for Insane at Essondale, B. C. It will have a capacity of 250 beds.

New Medical Director, The National Committee for Mental Hygiene

Dr. Frankwood E. Williams has been appointed Medical Director of The National Committee for Mental Hygiene to succeed Dr. Thomas W. Salmon, who resigned in January to become Professor of Psychiatry at the College of Physicians and Surgeons, Columbia University. Dr. Williams has been a member of the staff of the National Commit-

tee since January 1, 1917, as Associate Medical Director, Director of the Division of Education, and Editor of MENTAL HYGIENE. He is a graduate of the University of Wisconsin and of the Medical Department of the University of Michigan. He was formerly Resident Physician at the State Psychopathic Hospital, University of Michigan, Ann Arbor; Executive Officer and First Assistant Physician, Boston Psychopathic Hospital; Chairman of the Massachusetts Advisory Prison Board, and Medical Director of the Massachusetts Society for Mental Hygiene. During the war he served as Vice-chairman of the War Work Committee of The National Committee for Mental Hygiene and in the army as First Assistant and Acting Chief, Division of Neurology and Psychiatry, Office of the Surgeon General.

YALE UNIVERSITY HONORS MR. BEERS

At the recent commencement exercises, Yale University conferred upon Mr. Clifford W. Beers, the organizer and Secretary of The National Committee for Mental Hygiene, the honorary degree of Master of Arts.

The introduction by Professor William Lyon Phelps was as follows:

> "Clifford Whittingham Beers---A graduate of Sheffield Scientific School twenty-five years ago. His life has been filled with spiritual adventures. He is the author of a book apparently destined to become a classic, *A Mind That Found Itself.* In this, with unmatched eloquence of sincerity, he has described his terrific experiences in that obscure border-land beyond the bounds of sanity. On his return to the world of causation, instead of trying to forget his sufferings, he determined to use them for the benefit of mankind. He grasped the nettle Danger and plucked the flower Safety. Besides the extraordinary influence of his book, both in the field of literature and of human helpfulness, Mr. Beers has labored incessantly for the cause of mental hygiene. He is determined that people shall not forget those who have forgotten their own names. No explorer on land or sea has shown more inflexible courage than has Mr. Beers in penetrating beyond the frontiers of orderly thought."

President Angell responded:

> "For your indomitable courage and devotion in turning to the enduring benefit of mankind experiences that have driven most sufferers to silence and seclusion, we bestow upon you the degree of Master of Arts and admit you to all its rights and privileges."

This honor marks, as it were, the beginning of the international phase of Mr. Beers's unusual career. Mr. Beers is at present on leave

of absence from his office as Secretary of The National Committee for Mental Hygiene, and plans before many months to go to foreign countries to stimulate interest in existing mental hygiene organizations and in the formation of them where none exists. As secretary *pro tem.* of the International Committee for Mental Hygiene, now in process of organization, Mr. Beers will help establish that agency and, at the same time, further the plans for the First International Congress on Mental Hygiene, to be held in the United States, probably in the spring of 1924. The International Committee will be formally founded in connection with this congress. Countries already in a position to participate in this congress through having national committees, leagues, or councils for mental hygiene are: the United States, Canada, Great Britain, France, Belgium, and South Africa. Interest in organizing such agencies exists in Italy, Holland and other European countries, and in Australia.

British National Council for Mental Hygiene

Several months ago announcement was made that a provisional committee of British medical men had decided to form a National Council for Mental Hygiene, the aims of the organization to be (1) to serve as a medium for coördinating the activities of the various associations concerned with mental hygiene; (2) to join with other national councils to form an international league for combined action and the interchange of knowledge; (3) to study the causation and prevention of mental disturbances, including the influences of environment, heredity, such poisons as alcohol and lead, the dangerous trades, and syphilis; (4) to give greater prominence to the subject of mental hygiene in medical education; (5) to further the establishment in general hospitals of special clinics for the early treatment of mental disorders in such conditions as would remove the public prejudice against the word "*mental*"; (6) to improve the conditions of treatment of mental disorders, particularly in the early stages, when much good could be done at home by the institution of social work; and (7) to issue judicious propaganda.

The committee consisted of Sir Courtauld Thomson, Chairman; Sir Norman Moore, President of the Royal College of Physicians; Sir Charles Sherrington, President of the Royal Society; Sir John Goodwin, Director General of Army Medical Service; Sir George Newman, Principal Medical Officer, Ministry of Health; Sir Walter Fletcher, F.R.S., Secretary of the Medical Research Council; Dr. C. H. Bond, President of the British Medico-Psychological Association; Dr. Bedford Pierce, President of the Section of Psychiatry of the Royal Society of Medicine; Professor George Robertson, President-

elect of the British Medico-Psychological Association; Dr. C. S. Myers, F.R.S., Director of the National Institute of Industrial Psychology; Dr. G. Ainsworth; Dr. Helen Boyle; Dr. Edwin Bramwell; Dr. E. Farquhar Buzzard; Sir Maurice Craig; Lord Dawson of Penn; Sir Bryan Donkin; Dr. Elliot Smith, F.R.S.; Dr. Edwin Goodall; Dr. Henry Head, F.R.S.; Dr. H. Crichton Miller; Sir Frederick Mott, F.R.S.; Dr. W. H. R. Rivers, F.R.S.; Sir Humphry Rolleston; Dr. T. A. Ross; Dr. A. F. Tredgold; Dr. W. Worth. The name of Sir Leslie Scott, M.P., was later added to the committee.

A meeting, to which representatives both of the medical profession and of the lay public had been invited, was held May 4, 1922, at the rooms of the Royal Society of Medicine, for the purpose of deciding upon a constitution and electing officers. About four hundred people attended. Sir Courtauld Thomson, who presided, pointed out the need for a national organization which would enable Great Britain to take her place in the international movement for mental hygiene, and pleaded for the coöperation of the lay public, without which, he said, all the skill, devotion, and energy of the medical profession would be of no avail. Sir Humphry Rolleston explained in more detail the aims of the proposed council.

"It was then unanimously agreed", to quote from *The Times* (London), "that the National Council for Mental Hygiene be formed, and on the motion of Sir Frederick Mott, seconded by Dr. E. Farquhar Buzzard, Sir Courtauld Thomson was elected chairman.

"Lord Southborough proposed, Lady Darwin seconded, and it was agreed, that the provisional committee . . . be authorized to act for six months, with power to add to their number, to draw up a constitution, and to elect an executive committee.

"Sir Courtauld Thomson then announced that Sir Charles Russell and Company, honorable solicitors to the British Red Cross, had consented to act as honorable solicitors to the National Council; and Sir Basil Mayhew, auditor to the British Red Cross, had consented to act as honorable auditor.

"Dr. Henry Head pleaded for the coördination of the results of highly specialized scientific work which had been accomplished in relation to the mental health of the nation. The word 'mental' had an ominous sound which called up at once the idea of insanity. But mental hygiene meant only the maintenance of that state of health in which human beings could respond normally to the calls made upon them by daily life. Mental hygiene was as important as sanitation. Mind and body were inextricably intermingled. Those who played golf knew how completely they might go off their game. When they did, they wondered whether they were sickening for some illness.

When they returned home tired and vexed, they discovered the real cause in a forgotten letter thrust into a pocket unopened because of its disagreeable contents. This repression had been responsible for a day of misfortune. The evil effects of such repression was one of the most important therapeutic lessons learned in the war.

"No structural disease was free from its mental concomitants, and every mental state had its bodily equivalent. People said in a relieved voice, 'It is only nerves', but so-called nerves produced more individual and corporate misery than cancer. They were evidence that something was wrong beneath the surface of our mental life. Had a knowledge of mental hygiene been more prevalent, we should have been spared the crazy exhibition of suggestion to which this country had been recently exposed. We were advised, when a drain was obstructed, not to clear the effluent, but to say '*ça passe*', in the hope that thereby the noxious effluvia would be dissipated.

"Sir Leslie Scott, M.P., paid a high tribute to the work of the Central Association for Mental Welfare and After-Care Association, and said it was of the greatest importance that the various bodies dealing with the subject of mental hygiene should be kept in touch with each other by some unifying body such as the proposed National Council. Speaking from the point of view of the courts of justice of this country, he thought it was of the highest public importance that persons who committed crimes because they were mentally 'wrong' should be dealt with in the right way by medical attention, and that those who had to administer criminal justice should have the assistance of wise expert advice.

"Major-General Sir John Goodwin, Director General, Army Medical Service, said he was a little skeptical as to whether the day of the fighting services was entirely at an end. Modern war imposed a terrible mental strain, not only upon the fighting men, but upon the whole community; and he felt that the subject of mental hygiene was of incalculable importance to the nation's future.

"Sir Maurice Craig said it was poor economy to build vast institutions for the cure of the mentally afflicted. It would be very much better if more time, money, and thought were directed towards the prevention of mental disorders. Hitherto it had been the policy of this country with regard to a man who was breaking down that until he became insane nothing could be done for him."

The Lancet (London), commenting on the meeting, said: "The National Council for Mental Hygiene has started under the best auspices with a fine practical program before it, and it is to be hoped that the provisional committee will be able to take advantage of the opportunities for international activity which lie immediately before them."

Mental Hygiene in Australia

The Federal Executive Committee of the Public Health Association of Australia recently passed a resolution that a Mental Hygiene Section be formed with the following aims:

"To work for the mental health of the community; to help in the prevention of nervous and mental disorders and mental defects; to help in raising the standards of care and treatment of those suffering from mental disorders or mental deficiency; to promote the study of these subjects in all their forms and relations and to disseminate knowledge concerning their causes, treatment, and prevention; to obtain within the commonwealth and elsewhere reliable information regarding the conditions and methods of dealing with mental disorders and mental deficiency; to coöperate in accordance with the policy of the association with the various departments and other existing agencies concerned with these problems."

The first meeting of the section as a whole will be held in Sydney in September, when officers will be appointed for the ensuing year, preliminary organization discussed, and papers read. It is hoped that the section will be the forerunner of an Australian National Committee for Mental Hygiene and will prepare the way for Australia's participation in the work of an International Committee.

Congress of Mental Hygiene in Paris

A Congress of Mental Hygiene, under the auspices of the League of Mental Hygiene of France, which was organized in December 1920, was held in Paris June 1–4 in connection with the celebration of the centenary of Bayle's description of general paresis. The congress was designed to appeal not only to the medical profession, but to biologists, teachers, sociologists, lawyers, military men, and all others interested in the theoretical or the practical aspects of mental hygiene. The subjects of discussion and the principal speakers were as follows: *The General Principles That Should Govern the Care of Psychopathic Patients,* Dr. Antheaume, of Paris; *The Relation of Mental Hygiene to the Selection of Workers,* Monsieur Lahy, of Paris; *Applied Psychology and the Method of Education,* Professor Claparède, of Geneva; *International Coöperation in Scientific Studies in Mental Hygiene,* Professor Rabaud, of Paris; *Mental Hygiene in the Family,* Dr. Toulouse, of Paris. Dr. Toulouse, President of the League of Mental Hygiene of France, presided.

One of the aims of the league in organizing the congress was to prepare the way for French participation in an international congress of mental hygiene, plans for which are already being laid in the United States.

A Journal of Personnel Research

The Personnel Research Federation has recently issued the first numbers of a monthly journal to be devoted to "the correlation of research activities pertaining to personnel in industry, commerce, education, and government, wherever such researches are conducted in the spirit and with the methods of science". As the federation's official organ, the journal will represent a number of organizations of very diverse types. The active membership of the federation includes the Research Information Service of the National Research Council; the Engineering Foundation; the American Federation of Labor; the Carola Woerishoffer Department of Social Economy and Social Research, Bryn Mawr College; the Bureau of Industrial Research; the Bureau of Vocational Information; the Bureau of Personnel Research of the Carnegie Institute of Technology; The National Committee for Mental Hygiene; and the Department of Industrial Research of the Wharton School of Finance and Commerce, University of Pennsylvania. The need for a journal such as the one planned arises from this very diversity in point of view and in the matter of technical background and equipment among investigators of personnel problems. The federation aims to bring the various groups into touch with one another through the medium of the journal and to make the contributions of each available for all. To this end the style and language of the journal will be kept as simple as possible and as free from technical terminology as is consistent with scientific accuracy. The contents will consist of original articles, reviews, abstracts, and news notes. The following persons have been invited to serve on the editorial board: Editor-in-Chief, Leonard Outhwaite, Personnel Research Federation; Managing Editor, Clarence S. Yoakum, Director, Bureau of Personnel Research, Carnegie Institute of Technology; Daniel L. Edsall, Dean, Harvard Medical School; Alfred D. Flinn, Secretary, Engineering Foundation; E. K. Hall, Vice-President, American Telephone and Telegraph Company; Richard W. Husband, Dartmouth College; Wesley C. Mitchell, Director of Research, National Bureau of Economic Research; Lewis M. Terman, Leland Stanford University; Frankwood E. Williams, The National Committee for Mental Hygiene; Joseph H. Willets, Wharton School, University of Pennsylvania; Matthew Woll, Vice-President, American Federation of Labor; Mary Van Kleek, Director of Industrial Studies, Russell Sage Foundation.

Bulletin of the Massachusetts Society

The Massachusetts Society for Mental Hygiene has for the last few months been issuing a news letter—*The Monthly Bulletin*—with the

idea of keeping the members of the society more closely in touch with its various activities and with events of interest in the mental-hygiene field in general. Intended as it is for laymen, the *Bulletin* is written in language as non-technical as possible; its aim is rather to explain than to instruct. Dr. George K. Pratt, Medical Director of the Massachusetts Society, is the editor, and there is a consulting editorial board composed of Dr. Donald Gregg, Herbert C. Parsons, and Dr. Abraham Myerson.

Archives of Occupational Therapy

The American Occupational Therapy Association issued in February the first number of a bi-monthly journal, *Archives of Occupational Therapy*, which is to be its official organ. The new journal is to be used for the publication of articles that are now scattered in many periodicals or that lack entirely a proper medium of dissemination. News of ephemeral interest will not be published, as the plan is to include only material that is worthy of permanent preservation. The addresses and discussions of the Occupational Therapy Association will appear regularly, and constructive papers read before local societies will be included also. Abstracts, book reviews, and a current bibliography will help to keep readers of the *Archives* in touch with the latest developments in the field of occupational therapy.

The *Archives*, it is believed, will be of interest not only to workers in occupational therapy, but to physicians, social workers, nurses, kindergarten teachers and teachers of abnormal or subnormal children, psychologists, industrial-accident boards and departments, physical-education directors and directors of summer camps, and insurance companies, manufacturers, and business organizations interested in the educational and recreational value of occupational therapy.

Bulletin of Illinois Division of Alienist

The Division of Alienist of the Illinois State Department of Public Welfare is issuing a bi-monthly bulletin for circulation throughout the state medical service, including not only physicians, but nurses, attendants, occupational therapists, social workers, and all others who are concerned in giving therapeutic aid to the patients in the division's care. The purpose of the bulletin, as stated in the first number by Dr. Charles F. Read, State Alienist, is not to give orders, but to offer suggestions along various lines and in general to act as a stimulant. It will be concerned with administrative work only in so far as this bears directly upon questions involving treatment, hygiene, and sanitation. The contents will consist of brief articles, abstracts, recommendations for reading, short statements regarding the medical activi-

ties of hospitals in which especially worth-while work is being done, suggestions for the improvement of present conditions, and the like, no contribution to exceed three hundred words.

Progress

Man's rise from the level of the animal to that of a civilized human being has been due chiefly to his own efforts. While he depended on nature at first, owing to his limited intelligence, he rose higher in proportion as he used his mind in making it his servant. Proofs to this effect are accumulating every day. Climates which were deadly once are now becoming fruitful places for his enterprise. Fears which once terrorized him have been relegated into the realm of superstition. Diseases which once were deemed unavoidable now yield to scientific treatment. In the air and in the water, from the Arctic to the Antarctic, from the cradle to the grave, he becomes increasingly the master of nature and of his own fate.—Rudolph M. Binder, in *Health and Social Progress.*

American Psychiatric Association

The annual meeting of the American Psychiatric Association was held this year in Quebec, June 6-9. Among the topics discussed were *Endocrine Disorders, Psychoneuroses, Bodily States and Mental Disorders,* and *Childhood Psychoses.* The following officers were elected: President, Dr. H. W. Mitchell, Superintendent of the State Hospital at Warren, Pennsylvania; Vice-president, Dr. Thomas W. Salmon, Professor of Psychiatry, College of Physicians and Surgeons, Columbia University; Secretary-Treasurer, Dr. C. Floyd Haviland, Chairman, New York State Hospital Commission.

American Association for the Study of the Feebleminded

The Forty-sixth Annual Meeting of the American Association for the Study of the Feebleminded was held in St. Louis, May 18, 19, and 20. Among the papers read were the following: *Self-government as Applied to Feebleminded Women,* Mary Vanuxem, Psychologist, Pennsylvania Village, Laurelton; *The Relation of Personality to the Maladjustment of the Mental Defective,* Dr. H. W. Potter, Letchworth Village, Thiells, New York; *A Behavioristic Study of Delinquency,* Dr. H. M. Adler, State Criminologist of Illinois; *Extra-institutional Care of the Feebleminded,* Mrs. Z. Pauline Hoakley, Psychologist, Michigan Home and Training School, Lapeer; *A Study of the Careers of 321 Feebleminded Persons Who Have Been in the Special Classes and Are Now in the Community,* Dr. V. V. Anderson, The National Committee for Mental Hygiene; *A Report of a Study of One Hun-*

dred Feebleminded Girls with a Mental Rating of Eleven Years, Dr. George L. Wallace, Superintendent, Wrentham State School, Wrentham; *The Inauguration of a State-wide School Clinic in Massachusetts,* Dr. Walter E. Fernald, Superintendent, Massachusetts School for Feebleminded, Waverley; *The Institution as a Laboratory for the Public Schools,* Professor E. R. Johnstone, the Vineland Training School; *The Curriculum for the Children of Low-Grade Mentality in the Public Schools,* Lucy Elliott, Special Examiner in the Department of Tests and Measurements, St. Louis; *The Organization and Administration of the Education of Subnormal Children in the Public Schools,* Frank L. Wiley, Director of Tests and Measurements, St. Louis.

American Psychopathological Association

The Twelfth Annual Meeting of the American Psychopathological Association was held in Washington, D. C., May 1, 1922. The following papers were read: *Existing Tendencies, Recent Developments, and Correlations in the Field of Psychopathology,* by Dr. William A. White, Washington; *A Contribution to the Theory of Localization of Mental Functions,* by Dr. Harold I. Gosline, Howard, R. I.; *A Discussion of the Nature of Essential Epilepsy,* by Dr. L. Pierce Clark, New York City; *Psychopathology in Somatic Diseases,* by Dr. Smith Ely Jelliffe, New York City; *Relation between Psychoanalysis and Suggestion,* by Dr. John T. MacCurdy, New York City; *Current Expressions of Our Social Unconscious,* by Dr. Trigant Burrow, Baltimore; *A Discussion of the Mechanism of Obsessive States,* by Dr. T. A. Williams, Washington; *Depersonalization, or What Is Hypnotism?* by Dr. Morton Prince, Boston; *Critical Observations on "Phenomena of Materialization," by Baron Von Schrenck Notzing,* by Dr. Sanger Brown, 2d, New York City.

Mental-Hygiene Session of the National Education Association

The National Education Association, which met this year in Boston, July 2-8, devoted the afternoon of July 6 to a mental-hygiene program. The papers were: *Mental Hygiene for the School Beginner,* by William H. Burnham, Ph.D., Professor of Pedagogy and School Hygiene, Clark University; *The Inauguration of a State-wide School Clinic in Massachusetts,* by Walter E. Fernald, M.D., Superintendent, Massachusetts School for the Feebleminded; *Fatigue as a Factor in Education,* by Francis N. Maxfield, Director, Bureau of Special Education, State Department of Public Instruction, Harrisburg, Pennsylvania; *Some Internal Glandular Influences upon Child Mentality,* by Walter Timme, M.D., New York City.

A List of Books for Parents

The Committee on Bibliography of the Federation for Child Study has compiled a list of books for parents, on such subjects as the physical care of the mother and child, the philosophy of education, eugenics and heredity, play and recreation, sex education, adolescence, the unadjusted child, and the "new psychology". Among the books listed are *Speech Training for Children,* by Margaret Gray Blanton and Smiley Blanton; *Seven Ages of Childhood,* by Ella Lyman Cabot; *Human Nature and Conduct,* by John Dewey; *The Mind in the Making,* by J. H. Robinson; *Shackled Youth,* by Edward Yeomans; *The Direction of Human Evolution,* by E. G. Conklin; *The Control of Life,* by Arthur J. Thomson; *The Trend of the Race,* by S. J. Holmes; *Quicksands of Youth,* by Franklin Chase Hoyt; *The New Psychology and the Teacher,* by H. Crichton Miller; *Fundamental Conceptions of Psychoanalysis,* by A. A. Brill; *Human Behavior,* by Stewart Paton; *The Mental Hygiene of Childhood,* by William A. White; *Morbid Fears and Compulsions,* by H. W. Frink; *Psychology—A Study of Mental Life,* by Robert S. Woodworth; *The Psychology of Insanity,* by Bernard Hart; *Psychoanalysis, Its Theories and Applications,* by A. A. Brill; *Psychology from the Standpoint of a Behaviorist,* by John B. Watson; *A Study of the Mental Life of the Child,* by H. von Hug-Hellmuth; and *The Freudian Wish and Its Place in Ethics,* by Edwin B. Holt. Copies of the bibliography may be obtained by writing to the Federation for Child Study, 2 West 64th Street, New York City.

Neuropsychiatric Problem before Veterans' Bureau

According to compilations recently made by government officials, there are 9,027 ex-service men suffering from mental disorders in hospitals; and there are 110,000 claims for neuropsychiatric disabilities on file in the Veterans' Bureau. Thus, the Veterans' Bureau faces the large problem of restoring to mental health thousands of nervous and mentally affected veterans either in hospitals or in out-patient clinics. The bureau reports 34,554 mentally affected men who have been treated since their discharge. The Adjutant-General's Office of the War Department reports 72,000 men discharged from the service with mental disorders.

Of the recent appropriation of $17,000,000 provided by the second Langley Bill, which was signed by the President in April, a large part will go to hospitals for neuropsychiatric cases. Of the appropriation of $18,600,000 passed in the first Langley Bill, March 3, $7,792,000 was allotted for the construction and enlargement of neuropsychiatric hospitals. The Veterans' Bureau plans to have at least one

neuropsychiatric hospital in each of the fourteen districts into which the country is divided.

The neuropsychiatric hospitals at present in operation are located at National Soldiers' Home, Marion, Indiana; Naval Training Station, Great Lakes, Illinois; West Roxbury, Massachusetts; Philadelphia; Perryville, Maryland; Waukesha, Wisconsin; Augusta, Georgia; Knoxville, Iowa; Gulfport, Mississippi; Fort McKenzie, Wyoming; Bronx, New York; and Little Rock, Arkansas.

There are 5,500 beds in hospitals owned by the government. There are 4,500 beds in civil-contract hospitals. Thus, there are 10,000 beds now available for neuropsychiatric ex-service men. With the funds provided for in the second Langley Bill, the Veterans' Bureau plans to expand the capacity of hospitals to 12,000 beds. One of the problems of treatment in these cases is that of community adjustment; successful treatment is best effected in out-patient clinics. The first of these was established at Boston. Other clinics are now operating at Washington, Baltimore, Philadelphia, New York, Cincinnati, and Cleveland. It is proposed to have an out-patient clinic as a part of each district hospital. Occupational therapy is a part of the treatment. The bureau has provided for men discharged from hospitals—but not capable of going into regular vocational training—by establishing neuropsychiatric trainees. These are at Silver Spring, Maryland; Bellevue College, Nebraska; Port Jefferson, New York; and Chick Springs, South Carolina.

Lectures on the Mental Health of Children

A course of fifteen lectures on the mental health of children is to be given next fall at Boston University under the direction of J. Mace Andress, Head of the Department of Psychology and Child Study of Boston Normal School. The course is designed to be of practical value to teachers, mothers, social workers, and all those who are responsible for the training of children. Regular university credit will be given for the course. A tentative schedule of the lectures, which will be given weekly, beginning September 25th, is as follows: *The Mental-Hygiene Movement—Its Significance for Education,* by J. Mace Andress, Ph.D.; *Mental Health and the Child of Pre-School Age,* by Douglas A. Thom, M.D., Chief of Out-patient Department, Boston Psychopathic Hospital and Director of Children's Habit Clinic, South Bay Union Settlement; *Development of Healthful Attitudes towards School Work,* by Arthur H. Kollom, Assistant Director, Department of Investigation and Measurement, Boston Public Schools; *The Nervous Child,* by L. E. Emerson, Psychologist, Massachusetts General Hospital; *The Spoiled Child,* by C. Macfie Campbell,

M.D., Director, Boston Psychopathic Hospital; *Behavior Problems and How to Meet Them,* by Abraham Myerson, M.D., Assistant Professor of Neurology, Tufts Medical School; *Juvenile Delinquency and Mental Training,* by William Healy, M.D., Director, Judge Baker Foundation; *Feeblemindedness as a School Problem,* by Walter F. Dearborn, M.D., Ph.D., Professor of Education, Harvard University; *Feeblemindedness as a Social Problem,* by Walter E. Fernald, M.D., Superintendent, Massachusetts School for the Feebleminded; *Pitfalls of Adolescence,* by A. Warren Stearns, M.D., Assistant Professor of Neurology, Tufts Medical School; *Mental Hygiene and the College Student,* by Frankwood E. Williams, M.D., Medical Director, The National Committee for Mental Hygiene; *The Proper Education of the Emotions,* by Miner H. A. Evans, M.D., LL.B., Boston; *Plain Speaking about Insanity,* by George K. Pratt, M.D., Medical Director, Massachusetts Society for Mental Hygiene; *The Mental Health of the Normal Child,* by J. Mace Andress, Ph.D.

A Bibliography for Courses in Mental Hygiene

A short bibliography for normal-school and college courses in mental hygiene has been compiled by Dr. Walter F. Dearborn, Professor of Education, Harvard University, and Lawrence A. Averill, Professor of Psychology, Worcester Normal School, acting as a subcommittee of the Committee on Education of the Massachusetts Society for Mental Hygiene. The bibliography, copies of which were issued with the May number of the society's *Monthly Bulletin,* is designed to serve only as an introduction to general mental hygiene. The committee is at work on similar lists for specialized branches of the subject, such as feeblemindedness, juvenile delinquency, and the like, and these will be published as soon as ready. The items on the present list are grouped under three headings: (*a*) books, (*b*) pamphlets published by the Massachusetts Society for Mental Hygiene, and (*c*) reprints from Mental Hygiene. The Massachusetts Society has arranged to have available for quantity distribution practically complete sets of the last two groups at a cost price of $1.00 a set. These pamphlets and copies of the bibliography may be obtained by writing to the office of the Medical Director, 1132 Kimball Building, 18 Tremont Street, Boston.

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BODY AND MIND: THE ORIGIN OF DUALISM*

SIR FREDERICK MOTT, K.B.E., M.D., F.R.S.

Pathologist to the London County Mental Hospitals; Director, Pathological Laboratory, Maudsley Hospital

THE problem of body and mind, or body and soul, is as old as civilization. The evolution of language has led to a dual terminology, the origin of which I shall point out later. So long as man analyzes his own feelings, so long must he use language in order to express to others his thoughts and so long must he have two sides to his nature—a bodily and a mental side; accordingly he is accustomed to accept this duality as obvious. At the present time human beings, with few exceptions, accept this duality of body and mind, and language is accordingly impressed with the idea of dualism, and we should not be understood by the majority of people if a new terminology were invented.

Dualism has been reaffirmed by experimental psychologists of the Wundt school, who have advanced the doctrine of psycho-physical parallelism which teaches that the series of bodily events and the series of psychic events stand in an inseparable correlation to one another; but that body and mind, though existing side by side, are separate. This is really a modification of the preëstablished harmony of Leibnitz, which Kant had already expressed in a special form. Now if we inquire into the origin of this dualism which exists in all human beings—savages, primitive people, or cultured people—we shall see that it is centered around death; the evidence of

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burial rites and customs universal in the bronze and neolithic ages shows that prehistoric man believed in an intangible, invisible spirit which left the body at death. The doctrines of the wandering souls of the Egyptians, of the stories of the Old Testament, of Homer, who speaks of life "flitting away like a dream", affirm that the body and soul are separable, are two different things, which during life stand in close connection with one another, but which are separated at death. There was also the prevalent belief that evil spirits could take up their abode in the body; insanity was thus accounted for, and it appears from a recent letter in the press that there are even doctors of the present day who believe in demonology. I suppose general paralysis of the insane in older days would have been attributed to an evil spirit, but we now know that it is due to the spirochæte of syphilis which has taken up its abode and multiplied in the brain.

It is probable that dream life has played a considerable rôle in the foundation of the belief in a soul that can leave the body and return; for in dreams people are carried away to far distant lands, talk to their friends, see and converse with those long since dead, and a natural inference is that in sleep some spirit leaves the body and wanders away—something invisible which has sensibility, feels, thinks, and acts, the same thing that leaves the body at death. This invisible, intangible something, the soul, is either feared or honored, and the whole mode of abstract thought of primitive people is centered round this point of view.

The problem of body and mind, and body and soul, was discussed by the ancient philosophers, and it is interesting to observe that the doctrine of Lucretius, based partially on the teaching of Democritus and Leukippos, was monistic. He considered the soul to be the vital impulse of all the organs and tissues of the body. The mind is in the head, which directs and controls the whole body. He states that "the mind is begotten with the body, grows up with it, and grows old along with it". There is much truth in this doctrine of Lucretius.

The furniture of the mind is the memory of experiences and the bonds that united them from infancy onwards. But the inborn characters play a very important part, not only in the development of the body, but also in that of the mind. These

inborn qualities are psycho-physical energy, educability, imagination, emotivity, temper, and a mental balance which depends upon the harmonious interrelation and integration of those qualities of the soil upon which the mind grows up along with the body. The inborn germinal qualities are dependent upon sex, race, and ancestry, and, combined, impress a personality on every individual that profoundly affects his reaction to environmental influences in response to the three primal instincts of self-preservation, propagation, and the herd instinct of conforming to social customs, traditions, and usages. Galton's inquiry into the history of similar and dissimilar twins showed that mental and bodily resemblances occurred in similar twins, and that whereas dissimilar twins brought up under the same environmental influences remain dissimilar as regards the innate qualities of mentality, similar twins brought up under different environmental influences remained the same. Before considering the mind in relation to the study of the brain in mental deficiency, I will give a short description of the history of the brain as the seat of the psyche or soul.

Aristotle considered that the psyche was in the heart and that the brain was a cooling organ. Hippocrates, the father of medicine, localized the psyche or mind in the brain, and this doctrine was upheld by Galen. Most authorities of the Middle Ages accepted the doctrine of Galen that the brain is the organ of mind or psyche; the Cartesian doctrine—according to which the mind was regarded as an invisible, intangible something inhabiting the body and not to be dissociated from the brain—localized the soul's dwelling place in the hollow spaces (ventricles) of the brain. Descartes, wishing to materialize the soul and being unable wholly to discard the Cartesian doctrine, localized the soul in a small gland, the pineal, situated in the center of the ventricles. Swedenborg, profiting by the discovery of the compound microscope by Leuwenhoek, localized the psyche in the cells of the great brain (cerebrum); these cells, of which there are millions, he called cerebellula. Then came Gall, who argued that the mind must be in the great brain, seeing that man's faculties were so much superior to those of animals, and that the great difference between the brains of men and the brains of animals was

in the size of the cerebral hemispheres. He also demonstrated the fact that this part of the brain was diseased and wasted in lunatics and idiots. The remarkable work of Gall is forgotten, and his name is generally associated only with the exploded doctrine of phrenology. In 1876 came the experiments of Fritsch and Hitzig, and later of Ferrier, and the establishment of the doctrine of cerebral localization; although the clinical observations of Dax and Broca, of Bastian and Wernicke, had demonstrated the fact that injury or disease of the left hemisphere in right-handed persons led to various forms of aphasia according to the seat of the lesion, and Hughlings Jackson, by clinical observations, had foretold localization of movements in the cortex. It was hoped that further observations in this direction would lead to the understanding of the higher functions of mind in relation to body.

But it was Darwin's theory of evolution and the descent of man that revolutionized biological science and led to the greatest advance in our knowledge of body and mind. His theory dispensed with dogma and tradition, enabling psychology to be placed under the biological sciences, with the result that many of the younger psychologists—especially those who are concerned with the study and treatment of disorders and diseases of the mind—have regarded psychology from a biological point of view. A pioneer in that direction was Henry Maudsley. In support of this view, I will quote a passage from the *Descent of Man* (page 79):

"It has, I think, now been shown that men and the higher animals, especially the primates, have some few instincts in common. All have the same senses, intuitions, and sensations, similar passions, and even the more complex affections and emotions, such as jealousy, suspicion, emulation, gratitude, and magnanimity. They practice deceit and are revengeful. They are sometimes susceptible to ridicule and even have a sense of humor. They feel wonder and curiosity; they possess the same faculties of imitation, of attention, deliberation, choice, memory, imagination, and association of ideas and reason, though in very different degrees.

"The individuals of the same species graduate in intellect from absolute imbecility to high excellence. They are also liable to insanity, though far less often than in the case of

man. Nevertheless, many authors have insisted that man is divided by an inseparable barrier from the lower animals by his mental faculties. I formerly made a collection of about a score of such aphorisms, but they are almost worthless, as their wide difference and number prove the difficulty, if not the impossibility, of the attempt. It has been asserted that man is alone capable of progressive improvement; that he alone makes use of tools, of fire, domesticates other animals, or possesses property; that no animal has the power of abstraction or of forming general concepts, or is self-conscious and comprehends itself; that no animal employs language; that man alone has the sense of beauty, is liable to caprice, has the feeling of gratitude, believes in God, or is endowed with conscience."

Darwin says: "I will hazard a few remarks on the more important and interesting of these points." He then gives a number of examples in animals in support of his theory. At the same time he admits freely that no animal is self-conscious, if by this term it is implied that he reflects on such points as whence he comes or whither he will go, or what is life and death, and so forth. But how can we be sure that an old dog with an excellent memory and some power of imagination, as shown by his dreams, never reflects on his past experiences, pleasures, and pains in the chase? This would be a form of self-consciousness. On the other hand, how little can the hard-worked wife of an Australian savage, who uses very few abstract words and cannot count above four, assert her self-consciousness and reflect on the nature of her own existence?

Remarking upon language, Darwin observes that the dog expresses in five or six different barks or tones our cries of pain, fear, surprise, anger—together with their appropriate actions; and the murmurs of a mother to her beloved child are more expressive than any words. Mrs. Leslie Stephens says that a dog does frame a general concept of cats or sheep and knows the corresponding words as well as a philosopher; and the capacity to understand is as good a proof of vocal intelligence, though in an inferior degree, as the capacity to speak. The difference in mind between man and the higher animals, great as it is, is certainly one of degree and not of kind (Darwin).

There are three primal instincts common to men and animals: self-preservation, propagation, and the herd instinct; and these three instincts are the springs from which the streams and rivers of mental activity flow. From the biological point of view, we must regard the body as a commonwealth of cells which has developed from a single cell—the fertilized ovum. Whether we trace its development ontogenetically or phylogenetically, we see the same order of things —increasing complexity and differentiation of structure and function, which necessitates an increasingly complex harmonious interrelation and integration of function for the commonwealth of the organism. In this respect it is very much like the social organism. This harmonious interrelation is brought about by (1) bio-physical processes in the nervous system, and (2) by bio-chemical processes in the organs and tissues of the body, the products of which are conveyed by the blood and lymph streams. Whereas cerebro-spinal sensorimotor processes can be precise, discriminative, and limited in intensity and duration, and therefore capable of infinite variety and refinement by progressive evolution, the biochemical processes—although capable of an extraordinary discriminative sensitivity—must be diffuse in their effects, unless they act indirectly through the nervous system. Although the brain is the organ that stores the memory of past experiences and the bonds that unite and recall them, thereby enabling the individual to adapt himself to environment in the struggle for existence, yet, strictly speaking, the mind is directly dependent upon the vital activities and harmonious interactions of all the organs and tissues of the body; for of what use would the brain be without the peripheral sense organs and the nerves that connect them with the brain and spinal cord? These are the avenues of intelligence, as was clearly recognized by Aristotle in his famous dictum, *Nihil in intellectu quod non fuerit prius in sensu,* which would be more correct if *et in motu* were added. But another fundamental function of the brain, besides the life of external relation, is the consciousness of the individual's own personality, his appetites and desires, which are due in great part to the organic and bodily sensibility that without cessation makes him aware of his existence and needs.

The vital impulse is in every part of the body, and it is certain that the more active the vital impulse in an organ or structure, the greater automatically is the supply of oxygen by the blood. Every particle of the body is as much alive as the whole and possesses a bio-chemical memory. In proof of this we know that immunity against disease is due to the body's having once defended itself against the toxins of a pathogenic micro-organism; its tissues are thereby sensitized against this particular poison, so that should the organism again attempt to enter the body, the defensive mechanisms are immediately mobilized and the organism destroyed before it can multiply in the body. Still more remarkable is the condition termed anaphylaxis, or an acquired hypersensitivity of the organs and tissue of the body against foreign substances, especially proteins. Thus, if horse serum is introduced into the body, all the tissues of the body are sensitized to resist this foreign substance; and this sensitivity, which is connected with colloidal changes in the tissues, increases day by day, so that after a week or ten days, especially in certain people with an idiosyncrasy, the introduction of a fresh dose of horse serum produces such an intense colloidal reaction in the tissues that shock, sometimes fatal, may occur.

A physical or chemical stimulus, connected with the primal instincts of self-preservation by the avoidance of pain and the capture of food, of propagation, and of the bonds of union of the herd, has continued for countless ages in the process of evolution and survival of the fittest, and a specific bio-rhythm to particular stimuli subserving these primal instincts has become fixed and organized in the bodily structures, especially of the nervous system, constituting thus a physiological basis for instinctive action. Associated with these primal instincts are the primitive emotions, or certain states of feeling and bodily reactions common to men and animals. These instinctive reactions may take place independently of consciousness—e. g., the decerebrate dog will, if it be injured, attempt to run away and it will turn its head round and show anger by exposing its canine teeth. Again, Goltz showed that a dog that had had the whole of its brain cortex removed had completely lost its memory, for it invariably showed anger at the approach of the man who daily fed it. This same dog also exhibited

the emotion of disgust, for nothing would induce it to eat meat made bitter with quinine—not even starvation.

The higher we rise in the evolutional scale, the more are these instinctive reactions brought under control by the highest functions of the brain. But Nature is unmindful of the individual and mindful only of the species, and in order that the self-regarding sentiment of man should not outweigh the instinct of propagation, has predetermined an urgent desire and attraction to the opposite sex accompanied by intense pleasure in the gratification of the sexual appetite. This desire, upon which so many of our mental activities directly and indirectly depend, is primarily due to the sensitizing influence of bodily structures on the brain, and I will now dwell a little more fully upon this point of view regarding body and mind.

The sexual hormones (from *hormao,* I excite), which determine the mental and bodily characters of the two sexes, are produced by special interstitial cells contained in the reproductive organs of the two sexes, and these hormone cells can and do functionally act independently of the germ cells. They exist prior to birth, and having determined the sex characters in the infant male, they soon disappear or pass into a resting stage until puberty, when they reappear and determine the secondary male sexual characters; a complete mental revolution then occurs and a vague longing, followed by an attraction to the opposite sex, is determined by the sensitizing influence of their internal secretion on the brain. If these cells are destroyed, sexual desire is lost. Many other facts could be quoted to show the profound influence of the internal secretions of the sex glands on mind and body. Another fact that speaks of the intimate relation of the sex organs to mind is the fact that a large proportion of the cases of true insanities or psychoses and psychoneuroses commence at the times when the sex instinct matures and wanes.

Again, the influence of the secretion of the thyroid gland on the development of the brain is shown by the fact that its absence in the infant is associated with cretinous idiocy. Administration of the gland permits the brain to grow and with it the mind develops. Older people, especially women at the change of life, suffer with a failure of secretion of this

gland, and a curiously characteristic bodily condition, known as myxœdema, occurs. With this there is a disappearance of the energy substance in the brain cells, and slowness of thought, slowness of speech, and frequently mental disorder. Administration of the gland restores the body and mind if it is not begun too late. Another ductless gland, which is no larger than a bean, seated in a little bony saddle (sella turcica) at the base of the skull, controls the growth of the body and is intimately associated with the reproductive organs. Still another gland, the suprarenal, contains a store of adrenalin which, when it is discharged into the circulation, stimulates the sympathetic nerves; automatically, under the exciting influence of the emotions of fear and anger, this substance, so discharged, acts as a powerful defense mechanism in the instinct of self-preservation by causing a rise of the blood pressure, a mobilization of sugar for the production of energy by the muscles for fight or flight, a stimulation of the heart's action, increase of the blood supply to the muscles, and increased coagulability of the blood, so that wounds are less likely to be fatal. Again, there is an intimate association between the development of the brain and the cortex adrenalis; also, between this endocrine organ and the reproductive functions.

I might go on at great length showing the importance of these ductless glands and of the autonomic nervous system in relation to the primal instincts and emotions.

In daily life human beings are largely occupied in the performance of purposeful habits having their origin in the satisfaction of these primal instincts common to men and animals: they are acquired consciously by imitation or invention, but, when perfected, the will has merely to initiate the action and the sensori-motor reflex mechanism unconsciously carries on. It may be considered that in the subconscious mind there are a series of reflex patterns which, when once started, proceed in orderly sequence, the pattern of the last incoming sensory stimuli serving as the pattern of the next coördinating directing motor stimuli. The highest psychic level (consciousness) does not take any active part, but is watchful that the purpose willed is fulfilled; for it exhibits awareness when this series of reflex patterns is interrupted or inefficient. We know from

experience how fear and apprehensive self-consciousness may interfere with the efficiency of any habitual action.

In proportion to the evolution of society and the progress of civilization, the social instinct comes to dominate more and more human thought and behavior. The bond of union whereby the members of the herd are willing to sacrifice individual interest and even life is the primal source of preservation for the herd, and to a certain extent, therefore, for its individual members. This instinct of the herd is, however, a device of Nature for the preservation of the species. It has played in man a predominant rôle in the evolution of language and abstract thought and the advance thereby of culture and civilization. The habits, customs, and social usages of the herd dominate human life in thought and behavior and they serve to control the instincts. Owing to overpopulation and crowding in cities, there has arisen among highly civilized people an increasing tendency to a disharmony between social and physiological conditions regarding the sex instinct and its natural gratification. The correlation of body and mind is conclusively shown by the fact that a complete mental revolution peculiar to each sex occurs in adolescence, and with it comes a new and great source of psycho-physical energy, the vital impulse to propagate, which the social instinct, impelled by the stress of self-preservation, is enforced to control by contraceptive methods, or—using Freud's expression—to sublimate, that is, direct into other channels—e. g., religion, art, music, literature, and sport.

The social habits, customs, and usages of the herd were and are still too often based upon tradition and dogma connected with mysticism and beliefs in the supernatural regarding body and mind and body and soul, and before biological science was illuminated by the theory of evolution, few people ventured to differ from the herd regarding dualism. We now realize that in each individual life the furniture of the mind is the memory of the conscious and unconscious experiences and the bonds that united them. There can be no mind without memory, and there can be no memory without body, seeing that all psychic processes are dependent upon oxidation processes of a bio-chemical nature. We cannot separate psychical from physiological processes.

The ego is aware of his individual personality by the continuum of subjective feelings arising from the whole body in its relation to its integral parts and as a whole to the external world. All experiences of the ego attended by deep feeling and emotional discharge strike at the very roots of the three primal instincts, and the physico-chemical changes therewith reverberate and reverberate in the preorganized emotive subconscious sensori-motor and vegetative systems. These nervous and bio-chemical preorganized mechanisms, which have progressively developed in the animal body as a result of evolution in the long procession of countless ages, have become endowed with a specific bio-rhythm attuned to the primitive self-conservative animal emotions—e. g., anger, fear, disgust, and the tender emotions connected with the sexual instinct. The sentiments and passions which are the outcome of the evolution and interaction of the primitive emotions with the established bonds of union of the herd are likewise endowed with a specific bio-rhythm. Consequently, an experience with an intense emotional tone, long after it has left the field of consciousness, may be still operating subconsciously by the involuntary and unconscious bodily expression of the emotions exciting the associated subconscious memory of the emotional experience, and this in its turn reacts on the body. A vicious circle is thus established by which we may explain (1) the perseveration of the hysterical derangements of mind and body caused by emotional shock, and (2) anxiety neuroses with a mental conflict involving a struggle between the instinct of self-preservation and the social instinct of the *amour propre*.

Hysterical disabilities afflicted a large percentage of the rank and file of the conscript armies in the Great War. The emotion of fear and the wish to escape an intolerable situation led by auto- and hetero-suggestion to various bodily defensive mechanisms, in the nature of hysterical paralyses, tremors, contractures, mutism, blindness, deafness, and their perseveration. These could be prevented largely by suggestion associated with good discipline, morale, and *esprit de corps*. It was found that the number of cases in a regiment increased enormously where these were absent.

Men who had long suffered with tremors, contractures,

paralyses, mutism, and other disabilities which they had come to believe were permanent, were sent to me and were cured in a few minutes, a few hours, or a few days by various modes of contra-suggestion and persuasion, and, when cured, it was astonishing how completely changed was their mental attitude: the trembling, the cold blue hands and feet, the sweating, and the anxious facial expression—all signs of the emotion of fear—disappeared upon the bodily recovery and the breaking of the vicious circle. About 95 per cent of the cases of so-called "shell shock" were really emotional shock, and only 5 per cent were due to commotional disturbance produced by proximity to the explosion of a large shell. These were the true shell-shock cases, and if not immediately fatal, they recovered as a rule much more quickly than the emotional case, for the emotion of fear and the unconscious wish to escape from an intolerable situation were not usually a part of their mental attitude as soldiers.

Officers seldom suffered with these hysterical disabilities which were so common in the men; their nervous disability was usually an anxiety neurosis in which the instinct of self-preservation did not play such a dominant part as it did among the rank and file. An exhausted, irritable nervous system, associated with various forms of bodily derangement —e. g., headache, insomnia, tremors, and disorders affecting one or other of the following systems: cardiac, vasomotor, respiratory, digestive, genital, and glandular—was the result of a mental conflict in the conscious and the subconscious mind between two primal instincts—self-preservation and the esteem of the herd. In some the fear of death played the more important part. In others it was an altruistic fear connected with responsibility for the lives of the men under their charge, rather than their own self-preservation, that led to the nervous breakdown. Most of those officers who suffered with an anxiety neurosis were troubled with terrifying dreams of their battle experiences; some suffered with a recurring dream in which they lived over again some horrifying or terrifying experience so vividly that they were afraid to sleep. Some were unable to recall their dreams, but the mental and bodily depression on awakening showed that they had been dreaming of past painful experiences. Many shouted out in their sleep

commands to their men, and a few fought or walked in their sleep. The war has shown the great importance of the subconscious mind; but experience has demonstrated the fallacy of the Freudian doctrine that all dreams with fear are related to forgotten sexual experiences causing a mental trauma. Moreover, it has shown that individual self-preservation and a mental conflict arising from fear, associated with this primal instinct, suppresses sexual desire. It is interesting to recall that Shakespeare, in Mercutio's description of "Queen Mab", refers to soldiers' dreams; and in Lady Percy's speech to Hotspur attention is drawn to the mental conflict in Hotspur's mind and its interference with his marital duties.

But an individual suffering with an anxiety neurosis, which has its origin in the fear that he has irretrievably lost the esteem of his fellows, may arouse through the herd instinct bodily and mental effects similar to those produced by fear for self-preservation. This fact may be explained by the two instincts having been by evolution attuned to a corresponding specific bio-rhythm in respect to fear.

We cannot leave this subject of body and mind without a consideration of the doctrine of Hughlings Jackson's levels. We may consider that there are three evolutional levels in the nervous system, and this hypothesis is supported by comparative anatomy and the effects of functional and organic disease of the nervous system. The lowest level is present in all animals and subserves the primal instincts of self-preservation and preservation of the species. It consists of two parts: (1) the vegetative nervous system, consisting of two systems (a) the involuntary autonomic or parasympathetic, and (b) the sympathetic, with which are associated the ductless glands, and which controls and directs the bodily needs and functions concerned with gratification of the appetites and desires connected with the instincts of self-preservation and propagation; (2) the protopathic sensori-motor nervous system, which controls the reflex activities for protection against pain and injury, including injurious degrees of heat and cold.

The second level is the discriminative sensori-motor level. In the vertebrate series we find two great groups: (1) macrosmatic, in which the nervous structures that are especially developed are those connected with smell and taste: and (2)

microsmatic, in which the senses of sight, hearing, and touch are especially developed. The archicortex of the cerebral hemispheres is highly developed in the former, the neo-cortex in the latter. The projection centers of these senses are around the primary fissures.

The third highest level is the psychic level, in which there is a great development of the cortex of the brain, and which in man far exceeds in development that of the largest anthropoid apes. *Pari passu* with this great development of the cerebral hemispheres is a bodily development far surpassing in excellence all the lower animals: viz., erect posture—by which the forelimbs are no longer used for progression—and perfection of the hand, whereby it becomes not only the instrument, but the instructor of the mind, for, guided by vision, it is enabled to create and make the most varied mental adjustments to environment and control the forces of nature. By the creation of graphic and articulate language, which have simultaneously progressed, has been built up a great social heritage constituting an endowment to civilized man, whose organ of mind is, however, no larger or heavier, and possibly potentially no better, than that of the men who dwelt in caves 50,000 years ago—whose only common mode of expression was, it may be conjectured, mainly by vocal sounds, gestures, and facial expression, a primitive, universal, emotional language understood by all peoples.

Now, in idiots who are incapable of articulate expression and abstract thought, we find only the two lower levels properly represented; the development of the anatomical basis of the psychic level—i. e., the millions of cells in the cortex—is arrested in development and we have a condition, then, of amentia or absence of mind. If we examined sections of the cortex, we should find the supra-granular layer of pyramids especially affected. This layer, as Bolton has shown, is developed later than the infra-granular layer. Moreover, I have shown that as you rise in the zoölogical scale of vertebrates, it is this layer that increases in depth and number of cells.

Simple dementia or loss of mind may be associated with a limited destruction of the anatomical basis of mind—viz., the highest psychic level—and, the two lower levels being more or less intact, the habitual acquired sensori-motor reactions

may remain and the individual then may behave as an automaton in response to environmental influences and bodily needs. Every part of the body is represented in all the three evolutional levels and, as Hughlings Jackson taught, the last to come evolutionally is the first to go. The three physiological levels are functionally interdependent. The highest level, upon which awareness and volition depend, is able to act through the second discriminative sensori-motor level to alterations in the streams of sensation coming from the external world; while the third and lowest level evolutionally is concerned with the involuntary vital functions of the body, and therefore constitutes the basic source of the desires and impulses connected with self-preservation and propagation. I have endeavored in this address to show the inseparability of body and mind, and the importance of the study of biology and bio-chemistry in the study of mind in health and disease.

MENTAL HYGIENE NEEDS ARISING SUBSEQUENT TO SCHOOL LIFE*

C. FLOYD HAVILAND, M.D.
Chairman, New York State Hospital Commission

WHEN an adequate mental-hygiene program for the school period shall have become fully effective, it is certain that there will be a great diminution in the number of mental-hygiene needs arising subsequent to school life. Unfortunately it is needless to say that the school program has barely been undertaken, and the mental-hygiene needs of the adult population remain many and varied. It has been clearly pointed out that if the largest results theoretically possible in the mental-hygiene field are to be obtained, the potential sufferer must be reached in childhood, long before psychotic symptoms develop. Nevertheless, we have as yet, by and large, neglected the opportunity thus presented. The result is that we are left to work on the problem in its vastly more difficult phases, when character and habits have been rather definitely formed. It is the unhappy fact that the majority of individuals who seek aid in the mental clinics that are now carrying on preventive work are individuals who have already made measurable progress on the road to mental disease. This statement does not justify a pessimistic attitude toward the rôle of mental hygiene in the post-school period, but it does indicate the importance of undertaking preventive work to the fullest possible extent in childhood.

The mere extent of the problem of mental disease will ever render it necessary for the state to play the chief rôle in dealing with what is the most menacing of all social dangers. It is a fundamental duty of the state to maintain itself and to afford equal opportunity to its citizens. In formulating and carrying out a mental-hygiene program, it promotes both these ends. It thus accomplishes for the individual what the individual cannot accomplish for himself. Nevertheless,

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public mental-hygiene activities are not open to the charge of paternalism, so often brought against public-welfare efforts, for the very essence of mental hygiene lies in the proper stimulation of individual initiative and the proper development of personality.

It is unnecessary to emphasize to this audience the fundamental and far-reaching character of the relationship existing between mental disease and defect and all forms of asocial and antisocial tendencies apparent in modern life. We now recognize the futility of attempting to deal with such matters as delinquency, dependency, industrial friction, destructive radicalism, and the like, without taking into account the mental factors involved. We know that distorted or diseased mentalities are responsible for a large proportion of such unhealthy social developments, and we also know what can and should be done about it. If we possessed ideal facilities for the identification and treatment of mental disease in its incipiency, there is every justification for the belief that it would be revealed as increasingly susceptible of control and correction, with a consequent alleviation of the related social ills that have heretofore largely resisted successful management and that so often threaten the welfare and even the security of society.

Equal opportunity does not mean similar opportunity. It does mean an equal chance for successful social adaptation. But as capacities, both intellectual and temperamental, vary within wide limits, social and economic demands must be relatively commensurate with capacity if there is to be successful adjustment of individuals to environment with actual equality of opportunity. It is to such an end that mental hygiene addresses itself. There is thus no activity of a state more potent for good, more important for the individual or the state itself, than an adequately conceived and successfully executed program for mental hygiene. The promotion of mental health, the prevention of mental disease, and the provision of adequate treatment for mental disease, especially in its incipiency, promise not only more for human happiness, but more for human efficiency than any other mode of attack upon the ills of organized society.

An ideal program for mental hygiene thus comprises a far

larger field, not only for the school period, but for the post-school period, than any state has yet deemed it practicable to cover. However, certain states in recent years have made measurable progress in extending the scope of their mental-hygiene activities, especially in the matter of the treatment of mental disease. But possibilities will not be fully realized until there is general appreciation of the fact that prevention is greater than cure in the realm of mental disorder, just as in that of physical disease. And important as are preventive measures in childhood, they are of equal importance in later life, when the individual encounters an ever-increasing number of upsetting strains and stresses, presented by the most complex social structure ever yet evolved. Thus progress in mental hygiene may be measured by the growth of facilities for the prevention of mental disorders, no less than by the development of facilities for the treatment of mental disease.

But as is usually the case in movements to promote social welfare, theory in mental hygiene has outstripped practice. No state has fully met the immediate and obvious duty of providing adequate facilities for the care and treatment of those cases of extreme mental disorder designated by the legal profession as insane. No state has yet been able to do so, for the excellent reason that as modern facilities have increased, the number of known insane has increased—needs have continued greater than the facilities for meeting them. In all parts of the country there has been a constant parallelism between improved and increased facilities and the number of cases seeking treatment. It thus seems a fair deduction that the increase of known insane is, in part at least, due to increased confidence on the part of the public in public institutions—that a certain number of mental cases are not revealed in public records when public institutions render inadequate service.

The rather general increase throughout the country during the past two or three years in the number of mental patients under treatment in state hospitals demands the serious attention of all those interested in public welfare. For example, the net increase of patients on the books of the New York state hospitals, for the fiscal year ended June 30, 1921, was 1,442, the greatest increase of any year in the history of the

state-hospital system. While the rate of increase during the current year is somewhat less, it now appears that the net increase will approximate 1,200 for the year ending June 30, 1922. The cause of this increase is now the subject of a careful investigation by the New York State Hospital Commission, and while it is impossible at the present time to evaluate properly all the factors involved, there is reason to believe it is in large measure the reflection of economic conditions. Not only do periods of financial stress result in undue mental and nervous strain, producing mental disease in unstable individuals who might otherwise successfully cope with social demands, but they cause families and relatives of disabled persons to seek financial relief by throwing the burden of care upon the state, when in normal times they assume it by keeping patients in the home or in private institutions.

It is the obvious duty of a state to continue state-hospital construction to the point of providing bed capacity and treatment facilities fully commensurate with the need for them. In New York such a construction program is now in process of execution; approximately 1,400 additional beds will be available during the present year and approximately the same number next year. Present plans contemplate the provision of additional bed capacity each succeeding year until the present distressing overcrowding in the New York state hospitals, with its obvious evils, will be a thing of the past.

Aside from the provision of adequate bed capacity, hospital development must be considered incomplete until adequate living accommodations are provided for physicians, nurses, and attendants. Special equipment is valuable and necessary for successful treatment, but no equipment equals in importance properly trained, high-grade personnel. There is no substitute for kindly, sympathetic, tactful, and understanding human relationships, and the type of person the hospitals need can be retained in their service only as living conditions are provided that will approximate those obtainable outside.

In view of the urgent necessity of relieving the overcrowding that prevails in practically all parts of the country, it is absurd to think that patients are improperly detained in modern state hospitals, as is sometimes charged by the uninformed and ignorant. Most states have adopted a liberal parole

policy, which clearly shows that state hospitals are making every effort to restore patients to society as soon as is consistent with the welfare both of patient and of society. With a census of 42,400 patients on the books of the thirteen civil and two criminal state hospitals for mental disease in New York, over 3,200 patients are on parole. The number of patients on parole from the civil state hospitals has increased by nearly 1,700 during the past five years. The fact is that there is far more danger that a mental patient may fail to receive the indicated hospital care and treatment than there is that he will be improperly detained.

While treatment in a state hospital implies deprivation of liberty and hence the necessity of a legal process, it is to the interest both of individual and of state to make facilities for treatment readily available with as little legal hindrance as possible. The fear of illegal commitment is a heritage of the past and is based on false conceptions. While occasionally a technically sane person may be committed—such as a drug habitué, a defective without psychosis, or a dotard—it may be asserted that, under the enlightened laws now operative in many states, no person in a normal mental condition can be committed to a state hospital. The laws of New York respecting the admission of patients to hospitals are examples of these more enlightened statutes. They provide for the immediate or so-called emergency admission of patients certified by qualified medical examiners to be in need of immediate treatment, thus obviating delay when, as is still the case in many small and some large communities, suitable facilities are lacking for the care of patients pending commitment. There is also provision for admission on voluntary application when, in a superintendent's judgment, a patient's mental condition is such as to allow him to understand the nature of his act, but also such as to warrant treatment in a state hospital.

The operation of the voluntary-admission law has had a most salutary effect in emphasizing the hospital idea in contradistinction to the old "asylum idea", with its evil connotation. During the year ended June 30, 1921, 5.1 per cent of all admissions to the New York state hospitals were of the voluntary class, a percentage that has remained practically

constant during recent years, but only because of lack of facilities for the care of a larger number. There is no doubt that a state can well afford to encourage such admissions in greater numbers when accommodations render it possible to do so. It is thus possible to bring under treatment, at a time when treatment is of most avail, the border-line psychoneurotic cases, from whose ranks more frank psychotic cases come. There are private hospitals for mental disease with from 50 to 60 per cent of admissions on a voluntary basis, and while the demands on public institutions are such that it will probably never be possible for them to receive such a percentage of voluntary patients, it is wise state policy to render treatment facilities readily available to incipient cases. Recoveries are always in exact ratio to the promptness with which treatment is instituted.

Our modern state hospitals are hospitals in fact as well as in name, equipped as they are to deal not only with all types of mental disease, but with all forms of physical disease. Chief emphasis will ever be laid upon their curative efforts. But after all not more than 20 to 25 per cent of an average admission group is as yet recoverable, despite the application of our best knowledge and skill. That means there is an ever-increasing number of so-called chronic cases of mental disease in our institutions whose maintenance constitutes a tremendous financial burden. In the future development of hospital work, more effort should be directed toward securing such partial rehabilitation of the chronic deteriorated patients as may be possible. It is in this connection that the extension and further development of occupational therapy will find a great field of usefulness. Occupation for mental patients is not new, but it has heretofore been largely confined to patients who occupied themselves voluntarily. But now our chief concern is the idle and often disturbed and untidy chronic patients, with whom intensive and prolonged effort is necessary to secure results. But such results, when secured, are worth every possible effort. Through occupational therapy, habit training, and reëducation by means of simple kindergarten methods, there are relatively few chronic patients who cannot be trained to some useful activity and thus rendered able to fill a niche, however small, in the hospital organization.

The chronic wards of the future should be practically deserted after the household work has been done, as the patients go to the simple duties for which they have been trained. Occupational therapy of such an intensive character requires a considerable initial expense, but it is ultimately an economy, through the elimination of destructive tendencies and the transformation of patients from total liabilities to at least partial economic assets.

The bulk of chronic patients suffer from that form of mental disease known as dementia praecox, in which there are varying degrees of deterioration, but usually a final arrest of the deteriorating process on a lowered mental plane. Such patients, when trained to useful activity within the bounds of their diminished capacity, are comparable to defective persons similarly trained. Just as the latter now lead happy and relatively useful lives in industrial colonies, both in institutions and in the community, so may the industrially trained chronic mental patients become less of a burden in the small farm colonies that are becoming a feature of our state hospitals and that will be multiplied as the possibilities of occupational therapy are realized and means permit. It may even be possible to profit by the experience of our *confrères* in the establishment of industrial colonies for defectives in the community, as it would seem well within the bounds of possibility for such a colony of selected chronic mental patients to function successfully.

However well organized and equipped a hospital may be for the modern treatment of mental disease, it is to-day generally recognized that its extramural activities are fully as important as its intramural work. The isolated mental hospital, especially if mere custody be its chief function, is an anachronism. The present-day hospital must be a center from which radiates information on all matters pertaining to the maintenance of mental health as well as to the treatment and disposition of persons mentally diseased. It must reach out into the community in an effort to prevent mental disease and to secure the reëstablishment of paroled and discharged patients. To its primary function of treating mental disease must be added the function of preventing mental disease. The agency through which such work is accomplished is the

hospital mental clinic, with its associated social-service department. Primarily established to promote the parole of patients, mental clinics are now able to do considerable preventive work, attracting as they do not only potential mental cases, but friends and relatives of such cases. During the last hospital year, the forty mental clinics maintained by the New York state-hospital system were attended by over 13,000 persons, over 4,600 of whom had never been in a hospital.

Theoretically, clinic work should reduce the number of admissions to state hospitals, but, as already indicated, such a result has not yet followed. The explanation in part would seem to be that there are many more psychoneurotic borderline cases in the community than was previously supposed. Heretofore not susceptible to statistical treatment, such persons have not been identified as a group. Although a considerable proportion of them never develop a frank psychosis, there results from their mental disability an incalculable wastage of human energy and productiveness, not to mention the load of misery and unhappiness proceeding from ill adjusted, unbalanced lives. As a matter of fact, there are few normal persons who cannot profit from a knowledge of mental hygiene, which teaches self-knowledge and enables the individual to recognize and successfully deal with unprofitable and hampering mental habits and attitudes. Mental hygiene enables the normal individual to approximate more closely his potential possibilities and capacities than he otherwise could, and there are few persons who fail to realize that they do not attain the height of their possibilities. There is thus a mental-hygiene service to be rendered the entire community. We cannot too soon abandon the idea that mental-hygiene needs are confined to the mentally diseased or the mentally disordered.

Thus, even if mental clinics have as yet failed to reduce the number of patients admitted to the state hospitals, they perform an essential function which it is wise state policy to foster. To meet the needs of rural and small communities, some of the clinics may well be of a mobile character. Ready means of relief will thus be at hand for all those who need it, and preventive work on a state-wide basis can be undertaken. While primarily diagnostic and advisory centers, the

clinics should provide treatment for those who would not otherwise receive it, although, when possible, it seems desirable to make use of local psychiatric personnel and facilities in conjunction with those of the state. Local assistance and participation stimulate local interest, and local interest promotes permanency.

Just how many clinics are required to serve a given community is still uncertain, for as a rule the greatest difficulty experienced by the clinics already established has resulted from the unexpected numbers that seek aid and advice. In New York in no instance has a clinic been discontinued because of lack of patients. The problem has been rather how, with the relatively limited personnel and facilities available, to serve adequately all those who attend the clinics.

The success attending the campaign against tuberculosis has been largely due to the dissemination of information that has greatly altered the public attitude regarding this disease. It is no longer "the white plague", but a disease that can be and is being controlled to an extent deemed impossible but a few years ago. In the same way, dissemination of information as to healthy mental habits, the nature and danger of unhealthy ones, the perilous factors in an individual's environment and social relationships, will serve to rob mental disease of much of its mystery and terror and will induce a common-sense attitude toward it, akin to that now manifested toward the physical diseases that are yielding to public-health efforts. When such a common-sense attitude becomes generally prevalent, and only then, will mental disability lose much of its present power for evil. Hence, mental clinics have an important educational function. If the average individual could be made to realize that any radical change in a person's usual conduct, especially if abrupt and without assignable cause, may be indicative of mental disease, it is certain that many mental disorders could be avoided. But more often the onset of mental disorder is gradual and insidious, and so efforts must be made to inculcate the idea that any person who finds difficulty in self-guidance and in meeting the demands of daily life may be at least a potential sufferer from mental disease and one who can profit from skilled psychiatric attention.

No mental clinic can properly function without a trained psychiatric social service, which is perhaps the most important agency of all in spreading a knowledge of personal mental hygiene. The treatment of mental disease implies treatment of the social situation in which the disease appears and for which it may be in large part responsible. Thus the best results can follow only as means are available of gathering facts relating to home conditions, working conditions, amusements, and the predominant interests of the patient. Advice to a patient's family as to the attitude that should be assumed toward him not infrequently does more good than advice to the patient. Thus psychiatric social service is essential in any mental-hygiene program. Social service in general would have been the recipient of much less unfavorable criticism if social workers had had more psychiatric training, teaching them, as it does, how to recognize and successfully deal with all sorts of personal types.

While state hospitals should be and are prepared to treat all types of mental diseases, of which it should be remembered there are many, the majority of communities are at a considerable distance from these hospitals, and there remains a large field of usefulness in the principal centers of population for the so-called psychopathic hospital, conducted on the same basis as a general hospital, for the immediate active treatment of acute mental disorders. Where such institutions have been established, it has been found that it is possible to discharge without commitment the majority of patients who seek treatment, thus affording direct relief to the state hospitals. For instance, the Boston Psychopathic Hospital finds it necessary to commit less than one-half of the patients admitted. No type of institution does more to destroy the old fatalistic attitude toward mental disease than the psychopathic hospital. It demonstrates in a direct way by the results obtained that active treatment in the early stages of numerous types of mental diseases is effective. It teaches that a mental disability is to be regarded in exactly the same light as a physical disability—that the one is as much a disease as the other. It serves an important educational end, particularly in rendering available to the medical profession educational facilities in psychiatry comparable to those now existing in

other less important medical specialties. Psychopathic hospitals should, therefore, constitute a major feature of any general mental-hygiene program.

Practical considerations will ever restrict psychopathic hospitals to large centers of population, preferably in close relationship to medical colleges. In the smaller cities, psychopathic wards in general hospitals should be established to meet the same need as psychopathic hospitals in the larger communities. Local hospital authorities are apt to think that such wards exert a disrupting influence, notwithstanding the evidence to the contrary furnished by Pavilion F of the Albany General Hospital, which has for years served as a psychopathic ward, not only without hampering the other work of the hospital, but greatly aiding it. It should be the policy of a state to urge such wards in all general hospitals that can furnish suitable facilities. A lack of trained psychiatric personnel in many places will undeniably prove an obstacle, but if public opinion demanded it, the lack would be overcome. It is through the cultivation of such public opinion that mental-hygienists may properly seek the establishment of psychopathic wards in general hospitals.

It is evident from the foregoing that if a mental-hygiene program is to be effective, it must take on the character of a public-health movement, which, of course, it is. We have too long been obsessed with the idea that mind and body were distinct entities, to be treated separately. Happily, such an erroneous conception is fast becoming obsolete. A human being is a psycho-biological unit in which psychic and physical elements are interdependent, reacting one upon the other, with what we recognize as personality as the result. Health implies harmonious adjustment, both physical and mental, and hence no public-health movement is complete that fails to embody provisions for meeting the mental-hygiene needs of the community.

To recapitulate:

While preventive mental-hygiene work has its largest opportunity in childhood, mental-hygiene needs subsequent to school life are many, varied, and of the utmost importance.

The extent of the problem of mental disease renders it necessary for the state to play the chief rôle in dealing with it.

In formulating and executing a mental-hygiene program, the state promotes its own security and provides actual equality of opportunity for the individual.

The most obvious duty of a state in relation to mental hygiene is to provide proper and adequate facilities for the treatment of such cases of mental disease as are legally termed insane.

No state has yet been able to provide such facilities, owing to the increase of known insane.

The increase of insanity is, in part at least, more apparent than real, although depressed economic conditions are probably responsible for some actual increase.

Modern state hospitals for mental disease have developed parole systems whereby patients may return to the community under continued supervision. Community contact is increased through provisions for voluntary admissions, while provisions for emergency admissions are necessary, especially where proper facilities are lacking for the care of patients pending commitment.

State hospitals must be essentially curative institutions, although they have a function to serve in the partial rehabilitation of chronic mental patients. Reëducation of such patients through occupational therapy must be greatly extended, if hospitals are to reach their limit of service.

Institutions for mental disease must emphasize extramural activities no less than intramural ones, to the end that mental disease may be prevented and paroled and discharged patients may be reëstablished in society.

It is just as important to provide special facilities for the treatment of incipient mental disease as it is to provide means of treatment for the so-called insane.

Such facilities include out-patient mental clinics with associated psychiatric social-service departments, psychopathic hospitals on the same basis as general hospitals, and psychopathic wards in general hospitals in small communities.

No public-health movement can be regarded as complete that fails to meet the mental-hygiene needs of the community.

PSYCHOLOGY IN MEDICINE*

F. L. WELLS, PH.D.
Boston Psychopathic Hospital

LIKE some nations, psychology has in the past suffered from very artificial frontiers. Nor is it wise to define too exactly the boundaries of one's science. We are approaching a rather satisfactory conception. It is to regard as the subject matter of psychology those processes by which the organism reacts as a whole to the environment or to its own conditions. This may denote a broader field than previous attempts at definition, but it also implies more natural boundaries. The ambitious name of psycho-physics, for example, attached itself to a problem on the relation of stimulus and sensation which has a minor rôle in the psychology of to-day. Similarly, "personal equation" was spoken of as if it were bound up with the simple reaction time. One might recognize psychological sciences in somewhat the same way as physical sciences. Sociology and anthropology are such psychological sciences. So are the "science of human behavior" and the experimental psychology of university development, as well as comparative psychology. Psychological sciences are a natural division of biological sciences.

Psychology in one of its restricted senses is the science of the behavior of those who make up our social order. For the practical purposes for which it holds itself responsible, it distinguishes good and bad behavior according to the nature of the adaptation to the surroundings. Psychology has a legitimate interest in understanding anything that brings such conduct about. Any discipline concerned with the proper control of human conduct has a legitimate, not to say a responsible, interest in psychology.

* Read by title at the Seventy-eighth Annual Meeting of the American Psychiatric Association, Quebec, June 8, 1922. Published simultaneously in the *American Journal of Psychiatry*.

Medicine has long acknowledged and assumed responsibility for the behavior of most bodily processes as such. Disordered behavior of the organism as a whole has had relative difficulty in recognition as a medical function. This was a natural expression of the medieval dualism of body and spirit. "More needs she the divine than the physician", is the view of Lady Macbeth's much quoted medical advisor. The so-called insanities, the most socially disturbing types of behavior disorder, have been coming under medical supervision for upwards of a century. Medical supervision of feeblemindedness, and to some extent of criminality, characterizes certain advanced communities. It is difficult to shut one's eyes to the evidences of a broad current setting toward medical responsibility for the behavior, not only of the liver and pancreas, but of the organism as a whole.

But owing to the same medieval dualism of body and spirit, it came about that psychology, the discipline most directly concerned with the functioning of the organism as a whole, or the mind—whichever you prefer to call it—developed not as one of the sciences of medicine, but as a parthenogenetic offspring of the conventional mother of sciences, philosophy. Psychology thus acquired a stronger "mother fixation" than physics, chemistry, or astronomy. Only recently has it achieved a generally acknowledged place in the family of natural sciences. Its dissociation from medicine has been comparable to that of geology. The facts would justify a situation more like that with regard to chemistry. Chemistry denotes a field of knowledge perhaps no broader than psychology, though far more developed. Medicine teaches, and contributes largely to advance, that portion which is most relevant to medicine. Assimilation of psychology has been far less ready than in the case of chemistry, though there are branches of psychology of similar significance to psychiatric problems. The result is that non-medical persons may be confronted with medical problems on a relatively modest basis of medical equipment, and medical workers are asked to meet psychiatric problems with an important part of this equipment unsupplied. This is not to the interest of science, practitioner, or patient.

One should get over the practice of dissociating psychologist

and physician as if they were something mutually exclusive. There have always been and there always will be as good psychologists in the medical profession as out of it. Both psychology and medicine will be better off if a time comes when the term psychologist connotes physician not less nor more than does the term physiologist. This cannot be for years; things have moved too long and too far in a different direction. There is a group of us, not without group consciousness, whose business it is to meet certain problems that ought to be medical and unfortunately sometimes are. These problems were perhaps discovered by medicine, in the sense that America was discovered by the Vikings. But progress toward their solution has been very much the work of non-medical psychologists. The present dissociation is a logical result of the history of the two disciplines. I am doubtful whether it should be a permanent situation. If the attitude of medicine gave no prospect of a reasonable assimilation of psychology, then one could perhaps justify an effort to build up a discipline—not now existing—to enable psychology to do the best that could be done without medical affiliations. It was in this light that the matter at first presented itself to me. But when either path is open, as now seems certainly the case, it is well that psychology should weigh the issues very carefully before committing itself to an introversive development.

Medicine has "sold" itself psychology principally on the basis of the intelligence scales. Now there is a very human tendency to overlook the complications of a method none too well understood, when its results are expressed in plus or minus signs or a simple numerical term. So we are told that the only use of statistics is to refute other statistics. There is no doubt that the simple, global figure of an I. Q. often tells the data-hungry clinician somewhat more than it should. The psychologist cannot throw many stones here. But the uncritical use of psychometric methods in medicine is only less unfortunate than the ignoring of them altogether.

Desirous as one may be for the entrance of psychology into the family of medical sciences, one hardly wishes to see her do so as a poor relation. Out of this has probably come the feeling that a doctoral level only should be officially recog-

nized. Such recognition implies that one is competent to represent the psychological aspect of a problem in cases in which the authority for synthesis is with medicine, or to assume the authority for synthesis when it lies within psychology, as it might well do with an educational problem.

At this point one encounters a dislocation between psychology and psychologists. Psychology includes certain conceptions that have arisen under the influence of psychoanalysis, and with which non-medical psychology has had comparatively little to do. These conceptions did not develop as a part of the traditional psychology, nor has it found them very assimilable. As we know, these formulations are exceedingly speculative, but their serviceableness has been such that they deserve to form a part in every psychological system organized on inclusive lines. Their character is such that they could not well have originated outside a medical setting. There is hardly a motive other than the desire to be relieved from suffering that will lead to divulgence of the emotionally highly charged topics that are woven into the structure of psychoanalysis. There are non-medical psychologists who do very creditable psychoanalytic work, but without a closer contact between psychology and medicine than has yet been attained, the material of psychoanalysis will remain largely outside the scope and control of scientific psychology. Psychiatrists in general, and our own elder statesmen, are probably ready to agree that psychoanalytic work, like hypnotism, involves risks to operator and subject that should be most reluctantly undertaken outside the setting of responsibility that medicine traditionally provides.

The place of psychoanalysis in psychiatry is for the medical man to regulate. Something might be said, however, with regard to its position among psychologists. Extreme opposition to it seems rarer than among physicians. Probably most of us believe that it is a useful art. A few of us, while far from committed to its teachings as such, prize it highly for a depth of view that it has aided us to achieve. In point of scientific evolution, few, if any, of us, regard it as having passed, or as now engaged in passing, beyond the observational or "bug-hunting" stage. Its popular vogue is based mainly on the sanction it offers to erotic talk and ruminations.

Ideally, it is to experimental psychology something what the good hospital is to the good school. One renders essential service to acute individual needs; the other performs a broader and in the aggregate a greater service, if one of less imaginative appeal. To people who are in need of its services, psychoanalysis is worth more than psychometries. For society in general, it is doubtful if the entire structure of psychoanalysis is worth as much as the principal intelligence tests. This side of the shield is held up here because psychoanalytic writers sometimes base their comparisons of the two fields essentially on their pathological relations. For such a purpose one should take a broader view than is bounded by a consulting room and a library. The influence of experimental psychology in the matter of the direction of human conduct is both the greater and the more rapidly extending.

With regard to the exercise by psychologists of public functions, especially as concerns the commitment of feebleminded persons, it is hard to bring oneself to believe that any non-medical person should assume full responsibility for such commitment. Every case of mental defect is potentially a medical problem. Medical education and responsibility should always be represented in such cases. It seems equally proper, however, that there should also be represented in such councils the type of experience embodied in the American Psychological Association's Section of Clinical Psychology, experience which a committing physician has not always had the opportunity to acquire. A law to the effect that one of the committing officers must have psychological training of this level might well be advantageous in states like New York, where this type of expert knowledge is relatively available.

There is room for some solicitude about public protection against those who consider themselves psychologists seemingly with rather moderate insight into the limitations of their scientific equipment. But, as in similar situations in other fields, the fundamental remedy lies with the public itself. It is proper to ask of scientific psychology that it formulate adequate standards and make services governed by such standards reasonably available. The regulation of consulting psychologists by the general association, and the Psycho-

logical Corporation, are moves in this direction. The ultimate responsibility for public protection rests with the public.

The doctor of philosophical setting of psychology attaches special interest to codes that bring this issue into the laws regulating the practice of medicine. The issue is rich in casuistry. At least it is better to have people surprised that you haven't an M.D. than that you have. The assumption that a doctoral individual working in a clinical setting must be an M.D. is so deep-rooted that the most conscientious of us fall easily into a rôle of *medecin malgré lui.*

Beyond the avoidance of wilful deception, it would seem that the responsibility for this distinction could rest with society. It is but academic accident that has thus classified us as doctors with physicians, divines, osteopaths, veterinarians, and philanthropists, rather than with lawyers and engineers as plain mister, or as professors with philologers and tattoo artists. That it makes their work more effective is fair reason for applying the doctorate, in a medical sense, to persons who are candidates for the medical degree, and only the extremest among physicians asks for its discontinuance by psychologists. More real objection is not against the designation of doctor, but against the vagueness of this designation. A Ph.D. is no evidence of any training in the psychology with real medical contacts.

We are at a rather critical stage in the development of medico-psychological relationships. The next few years will weigh heavily in determining whether clinical psychology shall give rise to an independent group in quasi-rivalry with the physicians, or find a dominion status in the family of medical sciences. The former event would seem a precipitation rather than a solution—a regression indeed. Perhaps one sees most broadly when one focuses at a distance and looks beyond personalities to the terms of psychology and medicine. Surely it will be best for both when each learns with the most freedom from the other. In general the gains of science are the gains of the workers in that science as well as of society.

The failure of sciences with so much in common as psychology and medicine to amalgamate would not be a reassuring symptom among the complicated conditions that society

faces to-day. Medicine is the greatest human discipline under scientific domination; psychology is the organized study of human behavior; both are members of a house that should not be divided against itself. Science itself has yet to be "sold" to humanity. Perhaps the average man has an inherent preference for social control by hurrah. He is at least entitled to a fair choice. It is not a new sentiment that the future of civilization rests upon the taking of the helm by science, where politicians fail and even the older religions seem to be losing hold. One of its best expressions came, in calmer days than these, from an early work of the man who has made famous the name more obscurely carried by the present writer. Is it not interesting, by the way, that H. G. Wells published in his early days vision after vision of the future, and spends his later ones in compiling a survey of the past? As far back as 1900, his psycho-physician of centuries hence admonished the wreck of a decadent captain of industry in these terms:

> "You see . . . from one point of view people with imaginations and passions like yours have to go—they have to go . . . Die out. It's an eddy . . . We get on with research, you know, we give advice when other people have the sense to ask for it. And we bide our time . . . We know enough now to know we don't know enough yet. But the time is coming, all the same. *You* won't see the time. But between ourselves, you rich men and party bosses, with your natural play of the passions and patriotism and religion and so forth, have made rather a mess of things, haven't you? Some of us have a sort of fancy that in time we may know enough to take over a little more than the ventilation and the drains. Knowledge keeps on piling up, you know. And there's not the slightest hurry for a generation or so. Some day—some day men will live in a different way."

As to the bearing of such a homily on our own problems, the support of psychology belongs to any group of sciences according as it is able to carry scientific discipline into the affairs of men. As such, not a little share of our science belongs to medicine. As to the technique of infiltrating psychology into medical education, opinion inclines to premedical training for the general practitioner and graduate training for the specialist. The part that psychology has in industry would seem assimilable into the medical developments in industrial hygiene.

Thus the most hopeful outlook seems to be toward a fusion

of medical and psychological sciences into the best equipment for handling the adjustment problems of the human organism as a whole. Medicine and psychology together are a large order, and of course there are limits to the training the human mind can or should assimilate. Specialization is a partial answer, and another is the truism that it is not how much you know, but what you know and how you use it. It has been done before, "and then some", by an intellectual mastodon among our colleagues who dwelt in the seclusion of a small Middle-Western college some fifty years ago. We all remember the courtesy of the famous jurist who gave his seat to three women. This colleague of ours held the seat of learning for as many professors. To support the bulk of his vast and single intellect, his institution accorded him the chairs of "phrenology, penmanship, and hygiene".

THE IMPORTANCE OF A SPECIAL EDUCATIONAL TRAINING FOR MENTAL DEFECT DEPENDENT UPON ORGANIC LESIONS

L. PIERCE CLARK, M.D.
New York City

ONE would naturally infer that our knowledge of any particular nervous disorder would be materially advanced if two or more groups of special investigators approached the same problem, but this does not often hold true. Teamwork in medical research in this country is perhaps not so well organized as in some other branches of science, and these border-land studies and publications are somewhat better handled abroad. My remarks apply particularly to the advancement of our knowledge of mental defect.

Intelligent laymen would infer that inasmuch as the teacher, the psychologist (psychometrists for the most part), and the physician or psychiatrist (psychasthenists) are mutually interested in the problem of the feebleminded, the subject could not be better supported than on this tripod of investigation and that research would receive a triple impetus from such combined effort. But progress in the fundamental principles of education for children has made no material advance since the time of Froebel and Pestalozzi,[1] while education of the feebleminded child in particular is still slavishly following the "intellectualization of the senses" of the elder Séguin. Until very recently, psychometrists have been largely engrossed in more accurately enumerating the various intellectual defects of the obviously feebleminded child and have perhaps contributed no one really constructive program for solving the problem of the betterment of this class. The specially trained psychiatrist—the psychasthenist—has outlined no real advance either in classification or in specific diagnosis. So the field of psychasthenia remains almost

[1] Personal communication from Dr. Buck, Director, Geneseo State Normal College.

virgin soil for scientific exploration. No great advancement has been made in years, aside from the detection of the specificity of thyroid feeding in hypothyroidal states and cretinoid idiocy.

Why have we been marking time in this field of neuropsychiatry? Perhaps it is because it is one of the most difficult of all problems. From Goddard's data, although the validity of his evidence has recently fallen into disrepute, it would seem that a few years ago the genetic view of feeblemindedness purely as a hereditary causation could be accepted.[1] The experimental work of Stockard on animals, however,[2] and the biologic work of Davenport on the eugenics of family studies tend to discredit the purely genetic view of feeblemindedness and to prove that it must be seriously modified as the basis for even a tentative program. In point of fact, various accidental factors of imperfect development of germ plasm either before or after conception (Davenport), the exogenous factors or modifiers of the rates of development of the embryo and fetus (Stockard), the endocrine and toxic factors during gestation, both in the mother and the child, which later are expressed in mental defect (Weygandt), must give us pause in the evaluation of the genetic view that has been until recently held valid. The crying demand is for a department of research upon the broadest psycho-biologic lines, directed by one who will be able to coördinate all the special fields of research and assign them their proper places in this pressing problem.

1. There is need for better clinical departments in all institutions for feebleminded persons, the same to be conducted by trained psychiatrists supplemented by psychologists and lay assistants, the problem being medical, psychological, and educational.

2. There should be laboratories for clinico-pathological research. Associated with these laboratories there should be

[1] See *A Contribution to the Etiology of Feeblemindedness, with Special Reference to Prenatal Enamel Defects*, by L. Pierce Clark and Charles E. Atwood. *New York Medical Journal*, May 17, 1922, Vol. 115, pp. 543-79.

[2] See *Developmental Rate and Structural Expression*, by Charles R. Stockard. *American Journal of Anatomy*, January, 1921, Vol. 28, pp. 115-277. See also Stockard's discussion of Clark-Atwood paper. *New York Medical Journal*, May 17, 1922, p. 647.

an experimental and biologic station where control chemic and metabolic studies could be made.

3. The cost of caring for approximately 42,000 mental patients in public institutions and under private care in New York State was about 15 per cent of the total cost of the state's expenditures in 1920. Impressed by the magnitude of this problem, the state several years ago established a psychiatric institute, at an annual expense of approximately $50,000, for purposes of research into the causes and methods of prevention of mental disease. The number of feebleminded persons in the state institutions and at large is estimated at 45,000, thus showing feeblemindedness to be a problem as great as that of mental disorders (insanity). Yet there is practically no appropriation made either publicly or privately for any similar research into the cause and prevention of feeblemindedness. Until something of this sort is undertaken, we shall be swamped with theoretical matter and one-sided views of the etiology of feeblemindedness.

The practical part of my paper lies, however, in another division of this subject—namely, the lack of proper classification of the various accidental instances of feeblemindedness that are assembled for training treatment with those which we call the purely genetic or hereditary types. One would suppose that a difference in treatment of these two types would be axiomatic, but it is not; one is continually confronted with instances in which no difference in educational training is being made. In many neurologic discussions one hears the distinctly opposite view defended. An equally absurd position might be taken, for instance, that it is possible for us to make mental measurements of a large group of dementia-praecox patients and show from them that dementia praecox is preponderantly an issue of mental defect; but common sense and clinical experience prove this to be a fallacy in regard both to the nature and the treatment of this functional mental disorder. Perhaps we can make our point of most practical value by citing several cases in which the mere designation of mental defect in children was not sufficiently specific for a system of training treatment; and if such designation had been followed into a final disposal of the case, our plan of

mental training would have fallen short or have miscarried so grossly as to be of lasting detriment to the child.

Case 1 is that of a six-year-old girl suffering from what I have designated as cerebro-cerebellar diplegia. The case has been reported in detail in a paper published elsewhere.[1] At four and one-half years, it was noted that she had the repellent leer of a low-grade mental defective. She was speechless. Tests showed that the greater part of her apparent mental deficiency was overlaid by the motor defects. Instead of being sent to an institution for defectives, she was placed with private tutors under a system of training treatment especially adapted to overcoming her fearful handicaps. The principles upon which this training was based have also been thoroughly detailed in my report. The important result and most noteworthy fact to be mentioned here is that after a training of several years (she is now twelve years old) she has begun to attend common school and is nearly up to grade in classwork; she shows an almost uncanny genius for mechanical work and bids fair to excel in some artisan occupation.

Case 2 is that of a girl now fourteen years old. She, too, was reported in my series of cerebro-cerebellar diplegics. Her mentality, seemingly in greater part due to the definite nerve lesion, was four or five years retarded. She was placed in an institution for mentally defective persons for several years and was given the routine training, under which she did poorly. Efforts to explain the special nature of the mental defect—that it was conditioned in greater part upon the organic lesions induced at birth—were unavailing. She was then removed from the institutional system and placed under private and special tutors and with normal associates. As a result of this special and freer system of educational training, adapted to her unique type of neural and mental disorder, her progress in mental development has doubled.

Case 3 is that of a boy now eight years old. When first seen, at three years of age, he was a low-grade idiot, impossible of control or direction. His mental state was apparently secondary to a meningitis. The meningitis in turn was secondary to a double inhalatiou pneumonia from a severe chronic colitis at eighteen months of age. The boy was essentially normally endowed at birth, but had an acquired mental defect. He was placed in one of the best institutional schools for mentally defective patients for two years, but aside from improvement in conduct, he obtained little mental advancement. The school was apparently not willing or able to modify the educational training treatment of the ordinary so-called feebleminded child to meet the needs of this special case. When he first came under my observation, he could not express a want, depending on others to provide for him. He knew nothing at all about dressing himself and could not tell one garment from another. He spent his time roaming aimlessly about, usually holding on to some round object, such as a stick.

For the past two years he has been under private tutelage and training and has made remarkable strides in mental development. First we attended to his physical repair, for he was suffering from a severe colitis and had

[1] *Congenital Cerebro-Cerebellar Diplegics, with Notes upon Their Training Treatment.* *Medical Record*, May 5, 1917, Vol. 91, p. 755.

many stools each day. He gained in strength and became more physically active and it was then possible to give him mental and speech training. At first it was almost impossible to gain his attention for more than a few seconds at a time. He became cross and petulant under direction, and the work was necessarily slow. However, it was possible to add little mental drills each day until at last it became noticeable that he was beginning to pick up new words. First he expressed his wants by uttering one word; by carefully having him repeat little phrases that explained what his one word indicated, it was possible to get him to retain many words and phrases until he is now able to make up spontaneously short sentences. He understands any request, appears to have a rather remarkable memory as to where various articles are kept, and can procure them at short notice. He is becoming more and more spontaneous in his actions, and perhaps the best example of his progress is his ability to comprehend everything. He knows all the articles of his clothing, and aside from a slight deformity of the index finger of each hand which prevents him from being able to use these fingers in buttoning, he is able to dress and undress himself. At present he enjoys the best of physical health, is happy and contented, and shows more ability to create his own amusements.

From the foregoing illustrative instances, it would seem that there is a fairly large number of cases of truly accidental mental defects in which the antecedent fault of nervous lesion is overlooked or neglected in the educational training. In many such cases, the lesion may possibly be negligible in its impairment of the function of the brain as an organ of the mind, but not to take account of this partial impairment is to miss the point of the educational training treatment. Obviously, the undamaged structures are quite capable of undertaking the same or similar training as in one not so handicapped. If, on the contrary, the inheritance is much tainted, the possibilities for development even in mildly damaged brains are poor. We must be careful to apportion to each factor its proper rôle in the hindrance of development, and though the child appear very stupid, we should remember that surprising improvement may be expected in all children suffering from brain injury incurred at birth or in early life—exclusive of those suffering from hemiplegia with or without epilepsy. In this latter respect a double palsy or diplegia is much more hopeful in after-development than a strictly unilateral palsy. A part of the training is, of course, to be directed to overcoming or minimizing the structural defect in the brain, while the maximum effort in education should be but a modification of the so-called common-school methods. A matter of extreme importance for these children with

so-called gross organic mental defects is to gain as nearly as possible normal contact with normal children. The reverse principle and aim should be the rule in the care of the hereditarily tainted feebleminded child. Here, in fairness both to the child and to society, one should seek for the segregation of the feebleminded, to gain for them a uniform community life.

RESULTS AND FUTURE OPPORTUNITIES IN THE FIELD OF CLINICS, SOCIAL SERVICE, AND PAROLE*

DOUGLAS A. THOM, M.D.

Chief of the Out-patient Department, Boston Psychopathic Hospital

NOTHING that has happened in modern medicine during the past decade has been a greater boon to mankind than the development of an interest in psychiatry, both medical and social, on the part of the community. For the interest and enthusiasm, the toil and endeavor, necessary for the success of such a movement, the names of Richmond, Campbell, Southard, Jarrett, Cannon, and White will be remembered. Public interest in matters pertaining to the mental health of the individual was greatly stimulated by the recent war, so that psychiatry, almost completely ignored for generations even as a medical problem, is now receiving a cordial reception in many fields, such as the schools, the courts, and industry. In the great scheme of preventive medicine, psychiatry has taken its stand well to the fore. In practically every situation, whether it be medical, social, educational, industrial, judicial, or military—in fact, wherever two or more individuals are gathered together—the problem of human adjustment must be considered, and psychiatry in its broadest sense must play its part.

Surprising and regrettable as it may seem, the terms "mental hygiene", "social service", and "psychiatric clinic" are without meaning, not only to most laymen, but to many of the medical profession, who are struggling along blindly, quite ignorant of the facilities at hand. This failure on the part of the public to recognize the fact that the individual must be considered, not only as an isolated being, but also in relation to his environment and the problems that he has to meet in that environment, is perhaps due to the fact that too little stress has been laid upon the importance of presenting

* Read before the Mental Hygiene Division of the National Conference of Social Work, Providence, Rhode Island, June 29, 1922.

the utility and practicability of this broader conception, that we have dealt largely with rather vague generalities, and that no small part of the facilities that the mental hygienist and the propagandist discuss in public exist only on paper.

There is grave danger in that type of propaganda which has a tendency to stimulate the hopes of the public far beyond reasonable expectations. For years past we have been carrying on a most extensive program, providing for custodial care for the insane, the criminal, the pauper, and other unfortunates, preaching a gospel that would give the tax-payer every reason to believe that much could be accomplished in the prevention and cure of mental disease if provisions were adequate. When we are confronted with the facts of the case, however, we find that the discharge rate from our best mental hospitals is only slightly greater than the death rate. We speak all too glibly regarding the preventability and curability of mental disease. Important as it may be to maintain an optimistic and enthusiastic attitude on this subject, it is far more to the point just at this time to face the problem as it really exists and to provide for some practical solution.

The development of out-patient clinics must necessarily be limited by the personnel we are able to obtain, and we are confronted with the fact that neuropsychiatrists, nurses, and social workers exist in numbers that are in no way commensurate with the demands. It therefore behooves us, in drawing up any plans for the future that are to be at all extensive, to consider not only the problem of training personnel, but that of making the most of what we already have.

I know of no way in which the state can do more to care for the mental health of its citizens than by well organized out-patient clinics. Not only do they provide for the treatment of the maximum number of patients at the minimum cost, but they bring the patient into contact with the psychiatrist and his organization during the early and incipient stages of disease. Assistance is made available at a time when treatment is most hopeful, and when the patient is still capable of realizing his own needs. Treatment is given in a manner that makes it acceptable and compatible with the patient's social and economic obligations. It permits him to carry on his work during his rehabilitation and to continue to dwell in

the community, in the environment in which he must manage to live if he is to play a part in the social scheme of things. He learns to carry his burden, not by laying it down and retiring to an artificial environment, but by developing new methods of meeting difficulties, minimizing waste effort, permitting some one else to help in eliminating irritating environmental factors, and thereby overcoming worry and anxiety that are out of all proportion to the situation. Whatever the solution may be, if it is achieved without hospitalization, much has been accomplished for the individual and for the state.

This fact is being appreciated more and more, and the out-patient clinic is becoming a pivot point from which preventive medicine, in so far as it relates to the mental hygiene of the community, is radiated. Ministers, teachers, judges, probation officers, physicians, and lawyers are turning daily to the psychiatrist for advice in regard to the problems of human conduct. But he should not be satisfied with waiting for them to seek him out—he must penetrate and become part of their organizations.

If we consider the out-patient department as the hub of the wheel, the spokes will represent avenues of communication with the general hospitals, the schools, the courts, the various social agencies, industrial concerns, and the state hospitals. To a very large extent, patients pour in from these various organizations and receive their examinations and treatments at the clinic. On the other hand, the out-patient organization should be sufficiently mobile to permit one or more members of its staff to become temporarily part of any health movement that is being carried on, even though it may be quite independent of the organization with which the out-patient department is connected. Nothing except lack of time should hinder the psychiatrist from entering the school, the factory, the store, or the settlement house, and establishing a sub-unit that will greatly facilitate the work, rendering this service in a way that will be acceptable to the organization in question.

At the Out-patient Department of the Boston Psychopathic Hospital, we have one physician attached to the schools, another interested in two different clinics for children of the pre-school age, another in a health movement that is being carried out in East Boston, and two more who act as examiners

of the criminal insane, all these physicians being connected directly with the clinic itself. Such close coöperation between the out-patient clinic and the other organizations that it serves has the advantage of conserving personnel and permitting the various members of the staff to participate in the solution of community problems, giving the physician a broader vision and the community valuable service.

The medium of communication between the hospitals and clinics and those to whom they are endeavoring to render assistance is the social-service department. The out-patient department without a well organized, intelligently equipped, smoothly running machine to aid the psychiatrist in the adjustment of the economic, social, and educational needs of the patient is doomed to failure.

It is my opinion that too much importance has been attached to the necessity of drawing a sharp line of demarcation between the duties of the psychiatrist and those of the social worker. Too much time and attention have been given to debating whether this worker shall be a nurse, a teacher, or a college graduate. I do not mean by this to minimize the importance of selecting personnel for this type of service with the greatest care, for the tasks at hand require a nice judgment with a keen sense of social values and an unbiased mind—one that interprets situations, not from a moral, but from a social point of view. Resourcefulness and diplomacy, an interest in humanity and humanity's problems, and the ability to do teamwork, are all requisite for the success of the social worker. But these characteristics in themselves are not sufficient to assure success in social work, any more than they would assure the success of an individual in the field of medicine or law or in any other profession for which he had not adequate training.

It is easier and perhaps more logical to define the aims and purposes of social work than to make standards for the training that will accomplish the desired ends. There should, however, be an irreducible minimum in the matter of preliminary education and training which would protect not only the client and the public, but social work as a profession. It will be some time before we can hope for a large enough trained personnel—physicians, social workers, and nurses—

to meet the demand, and there is grave danger that in our effort to respond to present-day needs, which have been tremendously aggravated by the World War, individuals who are entirely inadequate will be accepted and recognized by both the medical profession and those interested in social work and will do more to bring discredit upon the profession in one or two years than can be eradicated in a decade.

One cannot read Miss Richmond's last book, *What is Social Case-Work?*, without appreciating the real value of the social worker and the tremendously important part that she plays in the great scheme of preventive medicine. Whether or not we agree with Miss Richmond when she states that "the central aim of social case-work is the maintenance and development of personality", and however intolerable it may seem to the medical profession to relinquish a certain amount of their authority and prestige to this comparatively new profession, the fact remains that, as Plato said, "there are diversities of natures among us which are adapted to different occupations", and, again, "all things are produced more plentifully and easily and of a better quality when one man does one thing which is natural to him".

I do not believe that it is necessary or desirable to define or limit the respective fields of the doctor and the social worker. Just as the treatment of typhoid fever is very largely one of good nursing, so the treatment of most of the problems of maladjustment is dependent on efficient social work.

I am quite in accord with Miss Jessie Taft, who stated at a recent meeting of the National Conference of Social Work,[1] "The psychiatric worker must make a real contribution, must supply the social knowledge and technique the psychiatrist necessarily lacks, and must be capable of extending his usefulness beyond the clinic or hospital by intelligent interpretation of his ideas." If the social worker is to contribute more than good intentions, human interest, neighborly visits, and advice, she cannot depend upon personality alone. It is quite essential that she have a training and an experience that will permit her to take her place with workers in other professions, as her responsibilities are no less important than those of the

1 See *Qualifications of the Psychiatric Social Worker.* MENTAL HYGIENE, July 1919, Vol. 3, p. 433.

doctor, the lawyer, or the judge. Her technique should be carefully developed along scientific lines, and new methods should be constantly studied with the idea of keeping pace with the other professions. Research should go hand in hand with routine. There is great danger of becoming too self-satisfied with the accomplishments already attained and of forgetting for the moment that the development of social technique is still very much in the making. Every department of social work should turn out at least one piece of research every year.

The psychiatric personnel in this country, as in every other, is, as we have said, quite inadequate to meet the demand. There is, therefore, a grave necessity for conserving the time of the psychiatrist in so far as possible, and there is no doubt but that the well-trained psychiatric social worker can assume more responsibility than we have heretofore permitted ourselves to believe.

Since the tendency is to broaden the scope of the social worker's functions and to increase her responsibilities, it will become more and more necessary for her to have not only a thorough knowledge of the community and all its resources, together with its dangers and pitfalls, but also an insight into the mental make-up of the patient as well as his social environment in order that she may evaluate properly all the factors involved.

If out-patient clinics and the parole system are to have the opportunity of demonstrating their practical value, the community must be educated to understand that there are certain responsibilities which it must assume. We are prone to shift burdens and discomforts to the other fellow's shoulders, and it is with great reluctance that we undergo any social inconvenience for the sake of our neighbor. We forget for the moment that our own escape from social catastrophies has been rather a matter of luck than of judgment or foresight. A little more consideration of our own good fortune would render us more tolerant of our neighbor's misfortunes—would perhaps make it easier for Mr. Jones to keep his defective boy at home instead of putting him into an institution, or for Mrs. Smith to treat more sympathetically the social indiscretions of her sixteen-year-old daughter; and it

may be that the old lady across the way could spend her last days at home instead of at the poor farm or the state hospital if just a little more patience and compassion could be stimulated in the younger members of the household.

We are all trying to get an environment free from responsibility, a frictionless sort of existence, forgetting that there are certain inconveniences, irritations, and social burdens which it is our duty, as citizens in a community, to assume and which we have no right to shirk. To make the community feel and assume its responsibilities toward those who are less fortunate is one of the great opportunities of the clinics and the social worker.

I know of no better example of what I mean by community responsibility than that which is exemplified at the little village of Gheel in Belgium. Many of you, I am sure, are familiar with this colony. Since the end of the sixth century it has been a refuge for the mentally disturbed. First those who lived nearby came to the tomb of the Virgin simply to pray. Later, pilgrimages were made from distant parts in search of a cure. The pilgrims procured board and room in the homes near the church, and from then on until the colony was reorganized by the Belgian state in 1852, much unorganized, though sympathetic work was done by those whose social heritage gave them more than ordinary insight in caring for the mentally diseased. In 1852, the colony was taken over by the state and has since achieved a world-wide reputation. After thirteen centuries of contact with the mentally diseased, the family care of the sick has become a habit almost necessary for the life of the population of this little village. But not all who wish may care for the sick. Before being accepted, the applicants must prove that they are of good character and that they possess certain surroundings of comfort. The choice of a family is the most important and delicate question to be met. An attempt is made to retain for the patient his natural habits of life. An artisan is placed in a family pursuing the same line of work as his own; patients who come from cities are placed in the families of citizens living in the center of the town, and peasants are lodged with farmers.

During the German invasion of France, the villagers of

Gheel opened their doors to refugees from one of the hospitals for mental disease on the border. I was told by Dr. Sano, Director of the Gheel Colony, that he never witnessed a more pathetic scene than the departure of these refugees from their Belgian hosts in the spring of 1919. These villagers are as much interested in their patients as they could possibly be in a member of their own family. I have visited their homes personally and have seen demonstrated there the true spirit of community responsibility.

It is too much, of course, to ask or to expect a duplication of the Gheel system, but it is not too much to demand more community coöperation than we are getting at present.

There are many ways in which the problems presented to an out-patient clinic might be divided, but for purposes of convenience and brevity, I will use a very simple clinical grouping—that is, into the psychotic, the incipient psychotic, and the psychoneurotic. Of the psychotic group, naturally a large proportion are referred directly to a state hospital. Many of these frankly psychotic cases, however, present no particular asocial traits and can be cared for quite satisfactorily in the community if adequate supervision can be provided. Not only can many of these cases be given the proper care in their homes, but they can be made economically independent, or at least partially so. I would call your attention to a recent article by Dr. George K. Butterfield,[1] of the Danvers State Hospital, which indicates that 40 per cent of the cases that were discharged against advice or that escaped got along quite successfully from an economic and social point of view after leaving the hospital, while 76 per cent of the cases that went out on advice succeeded. *I believe that with adequate social-service supervision* and with a well organized boarding-out system, there would be for many years to come *no necessity* for the present tremendous outlay on new construction in state hospitals in such states as New York and Massachusetts, and that if a small portion of the money saved could be used for research, something at least would have been accomplished in the way of eliminating the vast army of mental wrecks. I can only mention in passing the desirability

[1] *What Happened to Discharged Patients. American Journal of Psychiatry,* October 1921, Vol. I, pp. 177-82.

of having all patients who go out from psychopathic hospitals and state hospitals discharged through the out-patient departments, and the value of a well organized follow-up service which would permit us to see these patients as frequently as necessary for the purpose of preventing a recurrence of the mental breakdown that brought them to the institution. These cases are so numerous and so familiar to you all that I will not cite examples. Yet perhaps it is because of their very numbers and of the fact they are of such a common, garden variety that they are either neglected or ignored.

The second group, the so-called incipient psychoses, are perhaps of more practical interest, inasmuch as with them we can hope to do something in the way of genuine preventive medicine. It is our aim in dealing with these cases to forestall a mental breakdown by the application of the principles of mental hygiene. The following case is a good example of this group:

A young girl, nineteen years of age, was brought to the clinic by her father, who stated that for the past three or four months she had been telling most unusual and fantastic tales to the girls at the normal school that she was attending. She made it generally understood at the school that her mother had left her husband, had remarried, and was living in France. She showed her companions letters supposed to have been written to her by her mother. She discussed, rather intelligently, the economic, social, and educational conditions in France, and told of her plans to go there after finishing her course. Later on, she came to school and told of the death of her father, which created a great deal of sympathy among her friends, and immediately contributions were taken up to send flowers. It happened that this story became more generally known than the others she had told, and some one who knew the facts of her case communicated with the teacher. It was at this time that her fabrications for some months past were revealed, and she was advised by one of her instructors to come to the hospital.

She was a girl of more than average intelligence, had succeeded well in her studies, but had fallen down entirely in making friends and in getting enjoyment out of the more ordinary things in life. She was inclined to view life rather

seriously and had made but one confidante, a woman who had been her teacher when she was in the sixth grade. She had no intimate companions, and she felt that she had never been understood. She stated: "Mother half understands me, father not at all." Recently her school work had deteriorated in spite of the fact that she was staying up until four o'clock in the morning to get her lessons. A discussion of the situation with the father made it quite obvious that he had no understanding whatsoever of the girl's condition. He said: "Instead of bringing her here, I ought to put her up against the wall and smash her face." He felt that the fabrications were purely voluntary on her part, and that she was ashamed of the rest of the family. The mother seemed to be a rather sensible, hard-working woman, who, like the other members of the family, was very subservient to the father. She was making a great effort to shoulder the responsibilities of the household, not only caring for the house and for the three children's physical needs, but always having in mind that it was her duty to keep them happy and contented. She expected little and got less from her husband. From her story and the interviews with the father, there was no doubt that he was the dominant member of the family. Everything revolved around him, and he was most exacting in his demands for obedience. When he entered the house, the mental atmosphere changed immediately—everything must quiet down, meals must be served exactly on time, children must be put to bed at the proper moment, conversation must cease or be initiated by him. The wife stated: "He is a hard worker and a good provider, but the job of police inspector is extremely trying and nerve-racking." It was quite obvious that much of the irritability developed during his work was expended in the household.

It seemed quite apparent, from the analysis of this case, that the romancing and fabricating—for which, by the way, there were certain definite amnesic periods—represented an effort on the part of the patient to emancipate herself from the tyrannical autocracy of her father. The only road to happiness seemed to necessitate a withdrawal from reality and a refusal to meet the problems of everyday life as they were presented. It necessitated further the building up of a

little dream world of her own in which many of her desires, hopes, and ambitions could be realized. After going over the situation carefully with the mother and the father, it seemed advisable to change the patient's environment, temporarily at least. Fortunately a position was secured for her in a home as governess for two children, under very favorable conditions. At the same time opportunities of adjusting her life in a way more compatible with her personality were offered. Improvement was immediate and marked.

Such problems are being presented daily, and the solution of them is largely dependent upon efficient social service, the type of social service that can bring to the task an understanding of the mental make-up of the patient as well as the social technique required to handle an antagonistic, dominant individual like this girl's father, on the one hand, and the refined family in which the girl was placed on the other.

The psychoneurotic group makes up a very large per cent of all cases that receive treatment in the out-patient clinics, and it is with this group that we can best hope to be of real service. It is, perhaps, of interest to note that of all the patients seen at the out-patient clinic carried on by the United States Veterans' Bureau in Boston, less than 5 per cent are sent to hospitals for treatment, while in a Middle-Western city handling presumably the same group of cases, they find it necessary to hospitalize over 70 per cent of the cases. The reason for this wide discrepancy lies in the fact that in the one city there is a well organized out-patient clinic and an efficient social service, while in the other these facilities are not available. This is a good example of the value of clinics and social workers. Permit me, however, to present one individual case, with its ramifications, to illustrate how intricate and involved an apparently simple situation may become if intensively studied:

C. D., a woman fifty-six years of age, entered the Out-patient Clinic of the Boston Psychopathic Hospital complaining of weakness on the left side of the body, confined very closely to an extensive area that had been burned seven years ago, involving the left arm, breast, abdomen, and leg. There were also rather vague subjective sensations which were not

constant or characteristic of any nerve lesion. Careful physical and neurological examination revealed no organic cause for her complaints. In taking the history of the case, it was observed that the patient was depressed, extremely sensitive, and reluctant about going into the details of her early life. It was finally ascertained, however, that thirty-one years before she had had an illegitimate daughter by the man whose name she bore. Notwithstanding the fact that this man was a moral degenerate, socially her inferior, and abusive, she was extremely fond of him, and while not living with him, was at his command at all times over a period of twenty years. When their illegitimate daughter was seventeen years of age, her father had immoral relations with her which the mother knew nothing about until some years later. At the time of her coming to the clinic, the patient was living with this daughter—in fact, she thought that she was entirely dependent upon her daughter and her son-in-law—and it was made quite plain to her that she was not wanted.

This woman had converted many of her mental conflicts into physical symptoms. After going over the situation with her, a plan of life was outlined, and one of its most important features was that she have a home of her own. The patient then requested that she be allowed to bring her daughter to the clinic, and this she did.

The daughter was a well-developed and well-nourished young woman, thirty-two years of age, who was extremely depressed at the time of the examination. She gave a history of spells of excitement, when her thoughts seemed accelerated and prevented her from sleeping. Her married life had been extremely disappointing, as there was no real affection between her and her husband. She found life a very solitary affair, and could not meet people, as she was unable to appreciate any interest outside of herself. She was constantly seeking sympathy, attention, and romance. She had been extremely disappointed in not having any children and had made no effort to fill in the vacuum by outside interests. The husband of this woman was a hard-working man who had but little understanding of his wife's condition. He was, however, extremely coöperative and wanted to do everything that he

could to help out. He resented somewhat the presence of the mother-in-law and felt that much of their trouble was due to her interference.

The case was referred to the social-service department, it was arranged for the mother-in-law to establish an apartment of her own, and an effort was made to develop the daughter's interest in some of the social activities of the community. She took up gymnasium work and developed an interest in birds and flowers, and through constant attention and effort on the part of the social service, much improvement was made in the situation, to the satisfaction of all concerned. After a few months, however, the patient again became depressed and at the present time is just getting established again. The whole setting is quite obviously one for very intensive social work. The skill and ingenuity of any worker will be taxed to the limit to develop plans to solve this problem, and it is too much to hope that success will be achieved without one or more failures.

One of the chief rôles that the psychiatrist is called upon to play is that of arbiter. Some one has wisely said that "neuroses, like charity, begin at home", and this is well borne out by one's experience in out-patient work. The cases in which the solution of the problem depends in a large measure upon the proper adjustment of family situations outnumber any other group, and this is not surprising when one considers the intimacy necessitated by close personal contacts and the innumerable sources of irritation that are ever present. Many of the problems that are presented for solution are complicated and involved, but in general it is not so much the problem as the method by which it is handled that produces at first an unhappy mental atmosphere, later disputes and quarreling, and finally a situation in which more abnormal methods are utilized in an effort to bridge over the difficulty. These abnormal methods may be drugs, alcohol, convulsions, fainting spells, and not infrequently homicides and suicides.

I can only mention briefly a new phase of work started in connection with the Baby Hygiene Association which the psychiatrist and the social worker will coöperate in carrying out.

This is the establishment of habit clinics for children of the pre-school age. The study of children and of the influences that modify habits is what might be called a pure culture of mental hygiene. The heredity, personality, and environment of these immature children all need careful investigation. Instincts and emotions are studied in relation to the various personality defects or undesirable habits that usually make up the presenting symptoms. The opportunity for the application of high-grade social technique in this group of cases is unlimited, and the time is not far distant when this field will be receiving the attention it so richly deserves. The following are only a few of the typical problems presented at the habit clinics for solution:

P. F. Age two years, nine months. Beats, kicks, slaps, and bites other children. Has violent tempers and night terrors. Wets the bed every night; also wets clothing during the day.

J. Y. Age five and a half. Refuses food. Has fainting spells when threatened with punishment. Sucks his thumb.

F. D. Age three and a half. Intense fear of dogs. Very shy. Terrifying dreams.

I. S. Age five and a half. Refuses food unless fed by mother. When left alone with her food, hides it, and then tells fanciful tales of what has happened to it.

F. J. Age two years. Intensely jealous of little sister aged four. Resentful and sullen. Makes vicious attacks upon sister, usually biting and scratching.

H. H. and G. H. Ages five and six and a half respectively, sisters. H. H. for past three weeks has had persistent vomiting one or more times daily. Has always been a bed wetter. G. H. walks in her sleep and is also a bed wetter.

X. Age three. Very shy; always sits back and watches the other children at play, taking no active part.

X. Y. Boy sent in for cruelty. Tied cat and killed it, hitting it over the head, and so forth.

C. F. Age six. For the past two years has presented very marked sex interest. Takes her little sister to the park some miles away and leaves her. Goes out in the morning for school and does not return until late at night. Frequently picked up by the policemen. Hangs around the moving-picture shows, lies and steals.

D. H. Within the last six weeks since he has been on a farm, has developed unusually cruel tendencies. Was found on one occasion beating a newborn calf with a belt and buckle. On another occasion had gathered together with considerable time and effort a large pile of stones in such a strategic position that he could corner the cows and pelt them. Very ingeniously made a bow and arrow which he utilized to kill chickens, and never passed a cat or a rabbit without throwing stones. Investigation showed that these traits had been passed down through three generations.

My effort has been directed toward emphasizing what appear to me to be fundamental points in the organization of efficient out-patient clinics and the rôle that social work should play in the development of these clinics. To many of my readers I am sure it has been simply an elaboration of the obvious. Yet the profession of social work is young and in many fields not too well established, but little appreciated, and frequently only tolerated as a necessary evil. The idea is still prevalent that the highest aims and purposes of social work are to dispense advice to the patient and to make recommendations to the social agency interested in him. These ends are important and should not be minimized, but the really vital thing is the constructive work that can be done for the patient in helping him to meet the demands of the immediate situation, and this work requires personality, judgment, training, and experience. The recognized future development of social work, and the fact that its achievements must ever be closely interwoven with those of the other professions and of industry, demand ideals and standards that will not only insure its success, but will permit medicine, law, education, and industry to profit by its endeavors.

A STUDY IN CONSTITUTIONAL PSYCHOPATHIC INFERIORITY*

JOHN W. VISHER, M.D.

Twin Falls Clinic, Twin Falls, Idaho; formerly Assistant Surgeon (R), United States Veterans Hospital 37, Waukesha, Wisconsin

THE solution of the numerous psychiatric problems of the late war greatly advanced our knowledge of the broader aspects of psychiatry. The study of mental mechanisms and their effect on personality was especially fruitful. The fundamental lesson learned was that the psychogenic factor was of prime importance in the war neuroses. The recognition of this fact added impetus to the study of personality, for it was recognized that permanent relief of the war neuroses could be obtained only through such a study of individual cases. Thorough work disclosed many deviations occurring in all the attributes of the personality. A natural result was renewed interest in that small, but important group of inadequate personalities to which the name constitutional psychopathic inferiority is now frequently applied.

No other psychiatric disease group is the subject of so much discussion and difference of opinion. Many textbooks on psychiatry do not mention it, while others discuss it under various names. In 1835, Pritchard, a French alienist, applied the term "moral insanity" to "those diseases in which there exists a perverse state of feelings, temperaments, dispositions, habits, and actions, while the intellectual functions present no apparent abnormalities". Later, Lombroso attempted to define the born criminal and to identify him by physical stigmata. Diefendorf,[1] in his adaptation of Kraepelin's *Lehrbuch der Psychiatrie,* discussed the subject well from a descriptive standpoint under the term "psychopathic personalities". Tredgold[2] discusses this group under the head-

* Authorized for publication by the Surgeon General, United States Public Health Service. Read before the Section on Nervous and Mental Diseases at the Seventy-third Annual Session of the American Medical Association, St. Louis, Missouri, May, 1922.

1 Diefendorf, A. R.; *Clinical Psychiatry,* Edition 2. New York: The Macmillan Company, 1921. P. 516.

2 Tredgold, A. F.; *Mental Deficiency,* Edition 3. New York: William Wood and Company, 1920. P. 348.

ing "moral imbecility" and takes his definition from the British Mental Deficiency Act of 1913 which describes moral imbeciles as "persons who from an early age display some permanent mental defect, coupled with strong, vicious, or criminal propensities, on which punishment has had little or no deterrent effect". Rogues de Fursac and Rosanoff[1] describe the group under the heading "constitutional psychopaths", but include what are generally considered anxiety neuroses, psychasthenia, and moral insanity in their discussion. Salmon[2] says of psychopaths that "they have a tendency to react toward difficult situations in a neurotic or psychotic way, or have defects in volition or emotional control which make adaptations that are very simple for others very difficult for them".

Extensive experience with and intensive study of fifty typical psychopaths in United States Public Health Service Hospital No. 37, Waukesha, Wisconsin, has demonstrated the need for a more satisfactory definition. The following is offered as a working hypothesis and should be considered as purely tentative.

From the psychological standpoint, the constitutional psychopathic inferior presents marked inherent defects in volition and inhibition, together with a lowered threshold for and a disproportionate response to implicit and explicit stimuli. There is also a lack of balance in the various hereditary and acquired reaction patterns and habit systems. The individual is unable to adjust to his inadequacies, either by means of experience or by the formation of compensatory modes of reaction. From the behavioristic standpoint, the condition is characterized by marked egotism, impulsiveness, poor judgment, nonconformity to ethical and social standards, and inability to adjust to or to profit by discipline.

The defect in volition of the constitutional psychopathic inferior not only makes it difficult for him to concentrate or to apply himself, but also makes it almost impossible for him to hold to one course or action long enough to succeed. Hence,

1 De Fursac, J. R. and A. J. Rosanoff; *Manual of Psychiatry*, Edition 4. New York: John Wiley and Sons, 1916. P. 339.

2 Salmon, T. W.: *Some New Problems for Psychiatric Research in Delinquency.* MENTAL HYGIENE, January, 1920, Vol. 4, p. 37.

many become industrial misfits, loafers, beggars, and paupers. The combination of this quality with an unusually strong desire to travel produces the hobo and the vagabond.

His poor inhibition makes him particularly prone to the commission of crimes of passion and the perpetration of sensual excesses of all kinds. It is because of this inadequacy that a large proportion of alcoholics, drug addicts, prostitutes, and sexual perverts fall into this group.

His egotism, boldness, and vanity, as well as his tendency to become a leader of gangs, a fanatic reformer, an assassin, or an anarchist, are explainable by the mechanism of overcompensation. His irritability and his tendency to blame his family, his associates, his employers, the injustice of the law or of those in authority for his failure can be explained by the mechanism of projection. His inadequacies are subconsciously dominant, but he cannot consciously admit that they are the cause of his failure and therefore projects them upon his environment.

His emotional instability and impulsiveness bring him into continual conflicts with his family, his employers, and his associates. This maladjustment engenders innumerable internal conflicts and painful repressions. Bitterness, cynicism, and neurotic, psychoneurotic, and psychotic manifestations frequently result.

His lack of judgment distorts his point of view. It has been often truly said that the psychopath does not see things as they are. This makes him peculiarly liable to the development of numerous eccentricities and the adoption of unsound beliefs. Where there is also a lack of ethical sense, he too often becomes a crook, a charlatan, or a quack.

His nonconformity to social and ethical standards is due partly to his defective inhibition, partly to his emotional instability, but chiefly to his tendency to follow the course of least resistance. He does not profit by experience and teaching, and so follows his own inclination without proper thought of the consequences. The opinion of society has little deterrent effect. Hence, the psychopath commits numerous antisocial acts and feels no remorse. He lies, swindles, steals, and even kills to gain his selfish ends, without due consideration of possible retribution.

The cause of his inability to profit by discipline is evident from the foregoing description. It is especially important, however, for it explains the failure of our penal institutions in dealing with this class. In fact, Glueck[1] has shown that not only does the psychopathic group furnish a large number of the first admissions to penitentiaries, but it also includes an even larger proportion of the recidivists.

Statistical Study of Fifty Psychopaths

A very careful review of the hospital records of fifty psychopaths discharged from this hospital between March 30, 1920, and September 13, 1921, was made and certain statistical facts were gleaned that may be of interest. Although many of the statements of the patients were checked by information obtained elsewhere, it must be admitted that the data concerning industrial failures, arrests, and delinquencies are not in all cases entirely reliable. Since the patient was always given the benefit of the doubt, what errors exist are on the side of leniency.

A history of a neurotic family was obtained in twenty of the fifty cases. This means that one or more members of the patient's ancestors or their siblings showed evidence of a definite neurosis or psychosis or of aberrant conduct pointing toward the psychopathic.

The educational status of the fifty men is interesting in that over half attained the eighth grade or higher. The following table gives this information in detail:

Table 1—Educational Status

Left school in first to fourth grade	7
Left school in fifth grade	5
Left school in sixth grade	3
Left school in seventh grade	5
Left school in eighth grade	12
Left high school during course	10
High-school graduates	1
College graduates	1
Military college	1
Unascertained	2
Total	50

1 Glueck, B.; *Recent Progress in Determining the Nature of Crime and the Character of Criminals.* Reprint No. 116 of *Addresses of the National Conference of Social Work*, 1917. P. 10.

A study of the economic efficiency of the fifty before their entry into military service shows that eight had a good industrial record, eleven had a fair record, and twenty-five had a poor record. Of the remaining six, five had spent most of their life in the army since leaving school, and the record of one is unknown.

Twenty-six admitted having been arrested; nine had been confined to jail for longer or shorter periods; and two had served terms in penitentiaries. By accident it was learned that two others had been sent to reform schools. It is obvious that the above represents only a small proportion of the conflicts with the law that these men have had. The surprising thing is not that there are so few with a court record, but rather that any should have admitted that they had been arrested.

Their marital histories also show numerous evidences of maladjustment. Of the seventeen who have been married, three are separated, four are divorced, two have divorces pending, two are bigamists, and one has been married three times and divorced twice.

Adjustment was attempted by six by means of morphine addiction, and five others were addicted to the abuse of other drugs. Of the latter, acetanilide, "bromo-seltzer", veronal, sulfonal, and cocaine were the most important. Only two were definitely classed as alcoholic, though several others had drunk to excess at some time in their lives.

Military life appeals to the psychopath in many ways. It offers excitement, idleness, and male companionship. It is especially attractive as a socially tolerated outlet for the *wanderlust*, which is present in most psychopaths and was marked in thirty-four of our cases. Lack of adjustment to military discipline with resulting court-martials are not infrequent, though only two such trials were admitted by our cases. Deserters are common among psychopathic soldiers, but as they are not entitled to hospitalization, none of our series admitted such conduct. The more favorable side of the problem is illustrated by the following facts: Of the fifty psychopaths in this series, fourteen had entered military service from two to four times, while six were in the regular army and eight in the National Guard when the United States

entered the war. Only fifteen were drafted, while the remaining thirty-five enlisted. Ten were promoted—five to sergeant, two to corporal, and three to corresponding ranks in the navy.

The industrial record of our patients since discharge from the service demonstrates how completely military life unfits the psychopath for real work. Thirty-two of the fifty worked less than 10 per cent of the time from the date of their discharge from the service to the date of their discharge from this hospital. Table 2 gives detailed data concerning the percentages of time at work and time idle for the entire series:

Table 2—Industrial History since Discharge from Military Service

Per cent of time	Number at work	Number idle
10 per cent or less	32	3
11–20 per cent	4	3
21–30 per cent	5	5
31–40 per cent	3	5
41–50 per cent	1	5
51–75 per cent	2	16
76–100 per cent	0	10
Unascertained	3	3
Total	50	50

All of the nine men who were granted vocational training failed to complete their courses or to be even partially rehabilitated. Several tried more than once, and one tried three different courses, failing in all.

Failure in work and failure in vocational training, and the general restlessness and unhappiness resulting from poor adjustment, convinced the psychopath that his health had been ruined by his military duties. His friends and relatives too often agreed with him and confirmed him in his invalidism. Then, when a benevolent government offered him hospitalization and the hope of compensation, the final step in his downfall was assured, and he came to the hospital with his morale at zero, and his egotism, self-pity, and idea of his own importance at their highest.

A study of the series for organic factors shows that only three of the fifty men had somatic conditions of sufficient importance in themselves to warrant hospitalization. Four others had active venereal disease requiring treatment that

could have been administered in an out-patient clinic. Several others had minor organic conditions of which they were making capital, but which were either not disabling or were stationary in character, and obviously not in need of hospital treatment. So that in forty-seven of the fifty cases, hospitalization was chiefly for symptoms referable to constitutional psychopathic inferiority.

Hospital treatment of the psychopath is of little or no benefit to him and may be positively harmful, as it prolongs his invalidism. His influence upon the other patients is even more pernicious, as he is usually a fault finder and an instigator of trouble. Under these circumstances, the record of hospitalization of these patients in the military service and since discharge is of special importance. Table 3 gives the proportion of time spent in hospitals during service and after discharge from the service:

Table 3—Hospitalization

Per cent of time	Number hospitalized during service	Number hospitalized since discharge
10 per cent or less	16	10
11–20 per cent	5	11
21–30 per cent	7	7
31–40 per cent	9	6
41–50 per cent	6	4
51–75 per cent	4	5
76–100 per cent	1	5
Unascertained	2	2
Total	50	50

It will be noted that in each period twenty men spent 30 per cent or more of their time in hospitals. The average length of time spent in a hospital by each patient during and subsequent to service is 10.6 months, an astounding figure. Additional evidence of the magnitude of the problem is gained by a study of the number of hospitals in which each has been treated since discharge. Five had been patients in two hospitals; seventeen had been in three; and eleven had been in four or more hospitals. In addition, several had been admitted more than once to the same hospital. Probably many have been admitted to other hospitals since leaving this one, and doubtless the beginning has just been made in the institutional care of this group of social misfits.

Classification of Types

Careful study of these patients has made their classification into certain types seem useful. There are, however, no hard-and-fast lines separating these types, and reclassification may be necessary in the future. Each of the five following cases was chosen to illustrate a certain type. Additional types not illustrated are the chronic alcoholic, recently well described by Janet,[1] and the various types characterized by pathological sexuality, so thoroughly discussed by Krafft-Ebing.[2]

Inadequate-personality Type

N. F. S. was born in 1887, of Bohemian parents, in a small Wisconsin town. His maternal grandfather died at seventy in an old soldiers' home, while his father, who is sixty-three, has been in a charitable home for twelve years, apparently paralyzed. At the age of thirteen, when in the fifth grade, the patient was committed to the state reform school on the charge of incorrigibility and truancy. He remained there until seventeen, having finished the eighth grade. After release, he worked at many different jobs with only fair efficiency. He became a cornet player and played in several bands, and toured the country for several seasons with circuses and shows.

His habits, sexual and otherwise, were not unusual. He was compelled to marry at twenty-seven to legitimize a child, but separated from his wife a month later. He enlisted in the army June 21, 1916, and served on the Mexican border. He went overseas in February, 1918, but soon thereafter was hospitalized and remained in hospitals for eleven and a half months. The adjutant general reports that he was diagnosed "psychosis, hysterical and hemiplegia". While en route to Camp Grant for discharge, he went A. W. O. L. for eleven days. He was discharged March 9, 1919, without disability. Since discharge he has done no productive work. He started vocational training in tree surgery, but discontinued it after a month because he did not like it.

1 Janet, J. M. F.; *Alcoholism in Relation to Mental Depression. Journal of American Medical Association,* November 5, 1921, Vol. 77, pp. 1462–67.

2 Krafft-Ebing, R. von; *Psychopathia Sexualis.* St. Louis: C. V. Mosby Company.

He was admitted to this hospital April 14, 1920, and remained until July 2, 1920. He suffered with minor physical conditions which were in no sense disabling. The history given by him on admission differs markedly from the foregoing, and is full of proved falsehoods. It is of interest that he has "lost" his discharge certificate, probably intentionally. It was definitely proved that many of his alleged disabilities were simulated. For example, he claimed to have a paresis of the right side of the face and lips which prevented him from playing the cornet. This was shown to be spurious.

His conduct in the hospital left much to be desired. He was uncoöperative, unruly, uncivil, and often insolent. He was an instigator, continually stirring up discord. He paid no attention to the rules of the hospital. His delinquencies were numerous, but minor, as he apparently never committed any crimes. He did not like work and tried in every way to escape it. He has achieved his purpose, for, after leaving this hospital, he was given vocational training in chiropractic.

Hobo Type

W. G. R. was born in Chicago in 1892, of American ancestry and of good family. His early life was not unusual, and he finished grammar school at fourteen. He ran away from home at this time and has been leading the life of a hobo ever since. He bragged that he had been in every state in the Union as well as in Alaska, Canada, Mexico, and Panama, and that for two years he stayed less than ten days in a town. He traveled from place to place on freights or on the "blind baggage". He has worked as painter, structural steel worker, bricklayer, and carpenter. He has been arrested and jailed on several occasions for riding freights and for vagabondage. He has lived with several different women, but has never been married. He enlisted in the Engineering Corps of the army in March, 1918, and was sent overseas. He claimed to have overexerted himself rolling logs, and was treated in several hospitals for "nervous" symptoms. After discharge from the army, July 8, 1919, he recommenced his vagabondage, riding box cars from place to place and begging. For the eight months prior to his admission here, he had been treated in several Public Health Service hospitals. After he had

been here two months, the *wanderlust* again asserted itself, and he demanded his discharge from the hospital. He was very egotistic, self-confident, uncoöperative, fault-finding, and unruly. He had a marked, unwarranted hatred for his family. His inadequacies of personality, lack of ethical standards, strong sexual passions, and roving disposition had made a vagabond of him.

Pathological-liar-and-swindler Type

W. G. R. was born in Boston, Massachusetts, April 25, 1897, of English parentage. His father writes in the following manner concerning himself: "I was one of those hare-brained, foolish young fellows who did not care if I was in China or the United States of America. I loved to travel and never gave to-morrow a thought. I did not drink to excess. I was brought up well and in good surroundings, but was wild, full of nervous energy, and very sensitive; quick-tempered, fly up at almost anything, in fact out of all reason. My father was the same. This changed ten years ago. I have great self-control now." His father writes that he is a "government investigator" and has a large family. The patient's mother is living and is apparently quite normal, and his brothers and sisters show no marked neurotic taint. He was sent to school in England, but left at fourteen in the seventh grade of his own accord. At about this time he ran away from home without reason, but returned after ten days of his own accord. Later, exact date unknown, he ran away to enlist in the Canadian army. He became a sergeant in the Canadian Highlanders, but was not sent overseas and was discharged because of "physical unfitness". He joined the American navy May 3, 1920, and was discharged on medical survey September 14, 1920. He was at once admitted to the Marine Hospital in Chicago and remained there until October 29, 1920, when he was admitted here. He absconded from this hospital November 28, 1920, and returned to his father's home in Atlantic City, New Jersey.

Upon admission to this hospital, he gave a long, detailed account of his past life, telling of being a captain in the Royal Flying Corps, serving on the French, Italian, and Asia Minor fronts. He told of four "crashes" he was in and of long

periods of hospitalization for "shell shock". He claimed to have been in the air 2,250 hours. He said that his mother's hair turned gray overnight because of worry when he was flying, and that she died a week later of a "broken heart". He said that his father was a wealthy paper manufacturer and that he expected his father to furnish him with capital to start a shop in Chicago for the designing of women's gowns. While in the navy in the hospital, he told even more fantastic tales. He pretended to have a relapse of his "shell shock", collapsing when a truck back-fired near him. He did not walk for some weeks and demanded and received very special privileges. Upon leaving this hospital, he borrowed $15 from one patient, a suit of clothes from another, and a suit case from another, telling them that he was going on a pass. He left at least one hotel in Chicago without paying his bill. His father wrote of his son that "he would tell lies without any reason on earth for doing so". The patient appeared to be very refined, well-informed, and well-behaved. There was a certain personal magnetism about him that inspired confidence. He talked glibly and told his most fantastic yarns in so plausible a manner that he deceived every one for a time.

This case is remarkable in that it is almost a pure case of *pseudologia fantastica*. There were, to be sure, some unpaid debts and unreturned property, but the responsibilities of life rested lightly on his shoulders and he probably had no real conception of the gravity of his offenses.

Drug-addict Type

B. W. A. was born in Kansas City, Missouri, in 1896, of American parents, who were separated soon after his birth; he was adopted by foster parents at the age of three. His early life was apparently not unusual, except that he left home at sixteen and became a messenger boy. While engaged in this work, when seventeen years old, he acquired the heroin habit from the addicts to whom he carried the drug. He later worked irregularly as a chauffeur and as a dyer and cleaner, but admitted that he used to "hobo" three or four months of each year. The remainder of the time he would impose for the most part on the generosity of his foster parents, and, as he expressed it, "bum around town". At

about twenty he changed from "sniffing" heroin to using morphine hypodermically. He admits having been arrested many times, usually for morphinism, and serving several sixty-day sentences in jail. He stated that he had taken the "cure" at least eight times, though it is questionable whether he was ever off the drug entirely.

He was drafted September 3, 1918, but was discharged on Surgeon's Certificate of Disability for morphinism on March 10, 1919. He fraudulently reënlisted May 26 and was again discharged for the same reason September 8, 1919. During his second term of service, he acquired syphilis and gonorrhea. On November 11, 1919, he was admitted to a United States Public Health Service hospital and was treated for his morphinism on an open ward. While there he obtained all the drug he desired from outside sources, so did not benefit by his treatment. He was transferred from that hospital to this one, to which he was admitted February 24, 1920. Upon admission he said: "Unless you can give me some drug that will make me feel better than morphine, I would rather keep on taking it." He held to this attitude throughout his three and a half months' treatment here, which was directed chiefly against his syphilis and gonorrhea. For his drug habit he refused to accept treatment in isolation. He was surly, irritable, untruthful, and uncoöperative. He had numerous inadequacies of personality and used his morphine addiction as a means of sublimation. He knew from experience that without morphine life was to him a hollow mockery, and so clung to it as the only method he possessed of making life bearable.

Criminal Type

P. A. R. was born in a small town in Missouri of parents of Irish descent. His mother is markedly hysterical. He claimed to be unable to remember anything about his childhood, his schooling, or his occupation before entering the military service. He failed to recall even the town in which he lived before entering the service.

He enlisted in the army July 22, 1916, and arrived in France October, 1917. He served on several fronts, and his discharge certificate states that he was "wounded, gassed, and

shell-shocked''. He insisted that he remembered nothing about these experiences and repeatedly stated that he did not think he had been overseas. After returning from France, he was treated in several hospitals, but his memory of this period also was very hazy. He was discharged without disability. Since his discharge, he has done only a few weeks' productive work and has been living on his compensation. He was given placement training for a month, but failed to make good. He was treated in several other Public Health Service hospitals before being admitted here January 30, 1921. He complained of almost complete loss of memory for the entire period of his life except the last few weeks.

Extensive correspondence with American Red Cross chapters, Public Health Service psychiatrists, and police departments of cities all over the United States brought to light ample reason for this patient's apparent amnesia. He was released from the Indiana State Penitentiary to be allowed to enlist in the army. While in Paris, he was under indictment for stealing government automobiles. He pretended that he was the son of two different wealthy families by the name of R——, whose sons were unaccounted for, in an attempt to secure money from them. He was met by the father of one and the mother of the other upon landing in New York City. He eloped with a wealthy divorceé in her father's car. He tells several different stories as to the place and date of his marriage to this woman. At least once he impersonated an army officer, wearing a lieutenant's uniform. On one occasion, he traded off his employer's Ford as part payment on a larger car, and sold the latter, keeping the proceeds and telling his employer his car had been stolen. He stole another car in Detroit, sold it, and was brought back from California to answer to the charge. He has obtained money often from the American Red Cross on false pretenses. Special examination of eyes and ears demonstrated definite malingering. He made application for additional compensation, claiming two dependent children, and later admitted that he had no children. As a rule he was polite and agreeable, a very smooth and convincing talker, which doubtless explains how he has been able to escape imprisonment so

long. When questioned about certain of his past experiences, he would state that he remembered nothing about that period of his life; but when he learned that his questioner knew something about these episodes, his "memory" would return and he would explain away the difficulty very glibly, usually by means of more fabrications.

This case is typical of the more intelligent criminal who cleverly eludes detection and conviction. It is unusual, however, in the matter of the capitalization of an alleged amnesia. The pretended amnesia was truly spurious and could be quite completely dissipated by careful analytic psychiatric examination, but, as it had become a great asset to him, he could not be induced to relinquish it.

Diagnosis

The diagnosis of constitutional psychopathic inferiority can usually be made after prolonged observation and thorough study of the past history of the patient. It is essential to obtain information from outside sources. In this hospital, special stress is laid on the degree of industrial inefficiency, the evidence of social maladaptation, and the evidence of antisocial conduct. Special attention is also paid to the patient's conduct while under observation, his truthfulness, his amenability to discipline, and his relationship to the other patients.

In the differential diagnosis, the conditions that demand most urgent consideration are constitutional psychopathic state, constitutional inferiority, mental deficiency, psychasthenia, and hysteria. The first two might be more properly considered subdivisions of constitutional psychopathic inferiority, yet since they occur as definite, separate diagnostic designations in the nomenclature of the United States Public Health Service, the following differentiations or special characteristics are emphasized:

Constitutional psychopathic state is differentiated by the presence of such morbid manifestations as lie in the immediate foreground of insanity. Paranoid trends, altered psychomoter activity, disturbances of affects are common. There is usually no history of marked industrial inefficiency or of

antisocial conduct, and what gross maladaptation is present does not extend back to early life.

In constitutional inferiority, there is evidence of incapacity in the intellectual and physical spheres as well as in volition and emotivity. The psychopath is usually of good physique and of average or superior intelligence, while a constitutional inferior has usually a poor physique and a mentality that ranges from dull normal to true mental defectiveness. His failure in life is due to chronic inaptitude. There is usually no history of antisocial conduct, though there may be of delinquencies of a minor nature. If he lies, it is in a childish manner and not with malice or criminal intent. If he steals, it is to meet his personal needs only, and not to satisfy an exaggerated notion of wealth and ease.

In mental subnormality or deficiency, we have primarily a defect in intellect that can usually be quickly identified by a psychological examination. The mentally subnormal or defective, like the constitutionally inferior, usually react in a childish manner and rarely commit grave crimes or antisocial acts. The discussion of exceptions and combinations is beyond the limits of this paper.

In psychasthenia, we have more marked aboulia, with consequent irresolution and with compulsions, obsessions, phobias, and fixed ideas. The ethical and moral sense is usually normal or even exaggerated. The conduct is good, as a rule, and there is rarely a court record. However, in some cases, where the classical symptoms of psychasthenia are not typically present, or there is a suspicion that they are assumed, the differential diagnosis from constitutional psychopathic inferiority of the inadequate type may be exceedingly difficult.

In hysteria, also, the differentiation may be very difficult. The industrial efficiency is usually better in the hysteric and there is seldom a history of antisocial acts. The hysterical stigmata, such as anæsthesias, paræsthesias, paralyses, hypersuggestibility, seizures, and the like, are diagnostic when typical. Psychopathic malingerers can and do simulate these symptoms perfectly at times. Not infrequently we have cases that represent a mixture of constitutional psychopathic inferiority and hysteria which we variously diagnose, for

want of a better term, as "hard-headed hysterics", or as "hysteria with psychopathic tendencies", and as "constitutional psychopathic inferiority with hysterical manifestations".

Treatment

The treatment of constitutional psychopathic inferiority in the adult is very unsatisfactory. Their personalities are so inadequate that resolution of the conflict is often impossible. Permanent custodial care is indicated in many cases properly to protect them and society. Others may succeed temporarily or even permanently if under firm and wise guidance, especially if placed in situations to which they can adjust. Still others, who are perhaps less inadequate, find for themselves occupations or environments that hold their interest and satisfy their cravings. Not a few soldiers, sailors, traveling salesmen, peddlers, railroad men, explorers, and prospectors are sublimated hoboes. Many musicians, actors, professional boxers, and baseball players are psychopathic, and not a few poets, artists, reformers, and politicians must also be so classified. Thus many psychopaths who are pronounced misfits in one environmental setting may be eminently successful and socially very valuable in some other situation. The normal individual, on the other hand, is more versatile and can adjust fairly well to all situations.

The treatment of the psychopath, therefore, consists theoretically in choosing a vocation for him. Practically, however, vocational training as offered by the Federal Board for Vocational Training has been unsuccessful in dealing with this class of ex-service men. It is very difficult to find just the right vocation that a given psychopath should follow, and still harder to get him to attempt it. Often he has his mind set on something for which he is manifestly unfitted and in which he could not possibly succeed. Then, too, the appeal of the idleness and comfort of a hospital or an old soldiers' home, with a pension, is an impelling force directly opposed to and greater than the desire to make a *bona fide* attempt at self-rehabilitation.

In children, however, the outlook is much more favorable. The gratifying success of the juvenile courts and psychiatric

out-patient clinics with delinquent and maladjusted children has pointed the way to a partial solution of the problem. But even among children, many failures are inevitable. Adler[1] states that in Illinois the courts send to the reformatories only those children whom they have failed to reform, in "a last desperate hope" that these institutions may be able to reach them. In this, he says, they are rarely successful, and he goes on to plead for a more careful scientific study of this "junk pile". This is important, but it would seem that Richards[2], Kenworthy[3], and others in similar work, who are laboring with younger children, are more apt to succeed. If we can attack what Salmon[4] aptly calls "the habit of delinquency" at its very beginning and teach parents the importance of rational training for their children, we will be striking at the root of the evil.

Conclusions

To summarize, the following conclusions seem warranted:

1. The concept of constitutional psychopathic inferiority is not clearly expressed in the literature.

2. The intensive study of fifty psychopaths has led to the formation of a working definition from the psychogenic and behavioristic points of view, and to a tentative classification into types.

3. A statistical study of the case records is presented which includes evidence that military service greatly decreased industrial efficiency and led to prolonged hospitalization.

4. Treatment of the adult psychopath by psychotherapy, reëducation, and hospitalization is of but little avail. Vocational guidance is theoretically indicated, but practically is usually unsuccessful. In children, the results are better than in adults if the environment can be properly modified.

1 Adler, H. M.; *The Function of a Correctional Institution.* Mental Hygiene, October, 1921, vol. 5, pp. 778–83.

2 Richards, E. L.; *The Rôle of Situation in Psychopathological Conditions.* Mental Hygiene, July, 1921, Vol. 5, pp. 449–67.

3 Kenworthy, M. E.; *Extra-Medical Service in the Management of Misconduct Problems in Children.* Mental Hygiene, October, 1921, Vol. 5, pp. 724–35.

4 See note 2, page 730.

THE CHILD AND THE HOME

An Extract from a Survey of Mental Health Conditions in a Metropolitan District

MARIANNA TAYLOR, M.D.
Boston Psychopathic Hospital

THE term health, for so long limited to the physical condition of the individual, is now coming to be recognized as involving elements that make up personality. Many individuals are unhealthy whose individual organs show no evidence of disorder. They suffer from disorders in their emotional life and in their personality, and these are just as crippling as disorders of the heart or lungs.

In making a survey of the health of the community, it is important to keep these disorders in mind, to estimate their extent, and to consider what facilities are available for their treatment and prevention. The survey of the health of a district, therefore, will include not only attention to the extent of infectious disease, malnutrition, rickets, summer diarrhea, and so forth, it will also include an estimate of the mental disorders to be found in the community. Mental disorders are not notifiable in the same way as infectious diseases, so that accurate statistics are not available. Mental disorders include not only cases so severe as to have to go to a state hospital, but milder varieties of the same forms of sickness. They include also many forms of apparent physical invalidism, the roots of which lie in the mental life of the individual. They include many forms of poor conduct which are usually judged from ethical or legal standpoints and are not thought of as medical problems—e.g., alcoholism, delinquency, prostitution, and vagrancy. They include many of the difficulties of children, whether these be due to mental defect or mental instability.

A statistical survey of this whole field would be a very complicated matter. It would, however, deal with one aspect of public health that is of very great importance, that is to a

large extent neglected and ignored, and in relation to which definite practical preventive measures may perhaps be taken. It is not possible to canvass thoroughly even a small area with regard to the prevalence of the disorders referred to above. One has not the authority to ask for the information. The community is often not especially interested in the topic. There is, as a rule, very great reluctance to admit the existence of such disorders.

To demonstrate the actual conditions, to show the presence of important disorders that are, to a large extent, neglected, advantage was taken of the already existing agencies that do health work in this community. The workers were very much interested in this new approach to health problems, and appreciated the importance of the topics under study. It was felt that the most speedy and most concrete demonstration of the situation in regard to these mental disorders would be given by reviewing groups that were already known to the existing health organizations, and by looking for conditions of mental disorder or defect. There were several sources of material for such a review. It was possible to make a slight survey of the clinical material at the local dispensary, to see whether some disorders essentially mental were not masquerading as physical disorders. It was possible to get some data with regard to the extent of delinquency. It was possible to enter a random group of homes with a district worker, and to study the conditions under which children were being brought up and the presence of any mental disorders or defects among these children and their relatives. It was possible to get some data with regard to the number of patients from this district who have suffered from mental disorders sufficiently serious to require treatment in a mental hospital. It is obvious that in a brief and necessarily superficial survey of this type only illustrative material can be obtained. The most demonstrative material obtained was that which shows the actual conditions of the children in many homes in this district. One of the most important spheres of work in the prevention of mental diseases has to do with the conditions surrounding childhood. The data obtained from these homes are presented here in a very much abbreviated

form, but from them those interested in mental hygiene can gain food for thought.

Case 1.—The A— family are Italians of the better class, living under good economic conditions, in a comfortable three-story house. The father is a real-estate agent. The family consists of father, mother, and nine children, ranging in age from sixteen years to one day. These children have intelligent parents and live under favorable hygienic conditions and in a good neighborhood, yet three show marked signs of rickets—badly bowed legs, the deformity being so pronounced as to require operative treatment. Three are high-strung and neurotic.

A—, a boy, aged seven, is rachitic. He is restless and fidgety, and at times he stutters. There are choreiform movements of his hands. He tells how the American children next door throw stones at him and call him "wop", and remarks: "We get mad on them." His sleep is disturbed by terrifying dreams of a man killing him with a knife.

B—, a girl, six years of age, still soils herself and wets her bed, despite the fact that she has an intelligent mother.

C—, a boy of three years, strikingly handsome and the spoiled pet of the family, is the most extremely bow-legged of all. He is mentally bright, but uncontrolled, and the despair of the household. He is said to be "very nervous" and stubborn and to have frequent outbursts of temper, at which times *"he will draw a knife on any one"!* He bites the other children, will not let them touch his toys, and disturbs the peace generally.

Case 2.—A. B—, aged six years, is the youngest of a large family living under fairly good conditions. She is bright mentally, in the second grade in school, but is stubborn, spoiled, and difficult. She still talks baby talk, substituting w for r. Her mother considers her a "nervous child" and meets the problem by sometimes petting her and at other times angrily spanking her and shrieking at her. As a result, the child has tantrums and is disagreeable. She tries in every way to assert her independence and rebels against authority. She has a capricious appetite, is a restless sleeper, and has

terrifying dreams. By day she is preoccupied by fantasies. She is disciplined in such a way as to increase her neurotic traits.

Case 3.—The C— family consists of father, mother, and four children, aged four, six, eight, and ten years. They are Italians, living under good economic conditions. The boy of six is ill in bed with pneumonia, and because his family have never had any control over him, it is now exceedingly difficult to handle his case, making the outlook grave. He is "nervous", rebellious, finicky about his food, and refuses his medicine. Frequent slappings do not help matters. He screams and shrieks out to his bewildered mother: "Lie down with me or I'll die!"

The girl of eight years is pale and anæmic. She revels in the distinction of having had ether twice, because of an ear condition, and ether pneumonia two years ago. "If you don't let her have her own way, she kill herself."

Case 4.—The D— family, Italian, live in six rooms. The father is a fruiterer, and there are nine bright, alert, healthy children, the oldest sixteen years old and the youngest one day. The father came over to this country when one year old and is proud of his American citizenship. Six of the children are at school and are keen and alert, and insatiable readers, each getting one book a week from the public library. The oldest boy, aged sixteen, suffers from headaches and is very nearsighted. He is "nervous", and a bookworm when he is not working. He is very ambitious and very much alive.

Elsie, aged twelve years, sagely remarks about her mother and their new baby: "It's funny she never gets a girl! Boys are devils, and she gets them."

Thomas, aged two and one-half, sits solemnly by the stove, smoking a pipe constructed out of two clothespins and reading a newspaper. The others amiably keep telling him that the new baby now has his place, and do all in their power to make him jealous and irritable and at outs with his universe. They threateningly say that the visiting lady will take him away in her bag. He looks eagerly in the bag, hoping that the nurse may have secreted the unwelcome new baby in there

preparatory to kidnaping it. (Jealousy complex artificially encouraged.)

Case 5.—The E— family are intelligent English people, who live in a comfortable two-story house. There are two little girls, aged ten and two and a half years. The older is seriously ill with a heart condition and should be kept quiet and free from excitement. The younger child is bright and irrepressible. Her mother says she is "obstinate, stubborn, and wilful". She is fidgety and exigent. Her mother naïvely attributes this entirely to the fact that she herself was ill when she was carrying the child. Little Rose commands the father to bring her home presents every night and specifies what he shall bring. They always obey her for they "feel it is wrong to promise a child something and not do it". "If you come home without her present, there is a frightful scene." Little Rose, during the visit, danced about the room, irritable and thoroughly discontented. She repeatedly shook her sister's bed and behaved like a human cyclone. Her mother looked at her proudly and said: "Say your verses for the lady and I'll give you something pretty." Rose sulked and demurred, but finally craftily gave in and repeated a number of rhymes self-consciously, after which she said: "Now give me something pretty." "Hasn't she the grand memory?" said the proud mother. "She's awful smart. Emily is just like her, but her nerves are bad, so I don't teach her elocution, but she has talent." By way of making conversation, Mrs. E— said to Rose: "The lady will take you away if you're a bad girl. Does papa love you, dear?" she continued. "No!" shrieked Rose savagely. "Does mama love you?" "Yes." In this case it was learned that all the discipline given this unfortunate child is administered by the mother, the father being "far too kind-hearted"!

Case 6.—Charles and Frank F— live in a spotless Italian home. They are imaginative children, showing ability to amuse themselves and to invent games. They are active and full of energy and initiative, and keep busily occupied. Such children have possibilities if properly trained. They are naturally mischievous and always seeking an outlet for their

emotions. In consequence of this, the misguided parents scream at them to keep them quiet, but never either expect or enforce obedience. Like a whirlwind, the elders rush into the kitchen and pounce down upon imitation houses made of soap boxes, snatch them away, and shriek, calling the young pirates "bad boy" and "dirty" because they disarrange the kitchen. The play life is repressed as far as possible. The elder boy, aged three, has a stormy temper and is constantly fighting with the younger child, has a finicky appetite, and is underweight. He sucked his thumb until recently, but was cured of this habit by his mother's burning the thumb on a red-hot stove. The younger child, when he becomes a little boisterous in his play, is forcibly and roughly set down like a bag of meal on a chair. This treatment makes him cry rebelliously; whereupon a crust of bread is thrust into his mouth as a pacifier and silencer. This child, aged twenty months, does not yet talk beyond saying "papa" and "mama".

Case 7.—The G— family are Americans, living in squalor in three dark rooms. The father is a longshoreman; the mother has just been delivered of her sixth child. Three of the children are undernourished and anæmic and coughing constantly. All lack initiative, and are shy, silent, and inert. They look as if they had never smiled. They are utterly unresponsive. They are said to be "very good and to give no trouble". The three-year-old is evidently mentally retarded and apparently has defective eyesight. She is slow and dreamy.

Such a family as this need very special care and insight. The outlook at best is but poor, yet with better hygiene these children may be self-supporting as adults instead of a burden upon the state, as they bid fair to be if present conditions are not improved.

Case 8.—The one saving thing in the previous household was the arrival of Mary H—, who lives in the tenement upstairs. She reads to the lifeless G— children. Mary is a talkative, aggressive child of eleven years, eager to tell all about her family. She says she is "nervous" and that she

dreams and cries out in her sleep. She bites her nails, especially when she reads in school. "Mother hollers and scolds and tries to stop me, but I can't stop."

Her younger sister Martha is ten years old, and "she is always daydreaming. She sits still and never says a word, and then all of a sudden says: 'I dreamed——' And then she tells a long make-believe dream."

Robert, aged four, has "terrible tantrums". He has a frightful temper and pulls out his sisters' hair. He smashes up things generally, but the youngest, aged two, "is good and plays by himself all day".

Case 9.—The I— family are Italians in good circumstances and live in a sunny house fitted out with conveniences and nicely furnished. The mother is a buxom, showy type of girl, pleasant, but unreliable. She has a boy of four, a girl of two, and an infant two days old. The children are fat and sturdy. The mother talks about her children amiably, and their traits give her no concern. The little boy (he was late in talking and walked at thirteen months) she says "is so bold". "He throws the little girl down and fights her. He talks in his sleep and bites his nails." He doesn't mind, so his mother gets him out of her sight by turning him over to her relations, "because he makes her so nervous", and "they have a terrible time with him over there". He kicks and gets red and has brain storms, and bites other boys on the back. The family beat him, "but he does things just the same. He wants to have his own way, don't you know." *And he gets it!*

Case 10.—The four J— brothers, with their wives and children, live in one house, under fair economic conditions. The four cousins, three of them named Alice, play together.

One of these little girls, aged two, an only child, her mother describes affectionately as "a mean child who fights everybody". She cries if her mother leaves her for an instant. "She is her mother's baby." And so the mother never does leave her, and pets her and makes her more and more of an *enfant terrible*.

The children of these families, despite the fact that they are

called "fresh" and "bad" and "mean", are happy, normal, and in excellent physical condition. They are wisely fed, eat well, and sleep well. They have plenty of fresh milk to drink and are given cod-liver oil in addition.

The father of two of them has an unusually intelligent attitude toward their play life. In consequence, they are thoroughly happy and romp to their hearts' content, making all the noise possible. As he observes, it is a good thing there is no one living beneath them, for other tenants would not stand for such a bedlam. The little youngsters of twenty-six months and two years lie side by side on the bare kitchen floor on their backs and kick furiously, making a great noise with their new shoes on the wooden boards. Better exercise could not be prescribed to make them strong and to keep their bodily functions normal. When exhausted by this strenuous play, they get up and ride on their rocking-horses. This was one of the few families that had just been visited by Santa Claus—*the first home in this series in which there were toys of any description.*

Case 11.—The K— family consists of father, mother, and five children, aged ten, six, five (twins), and two years. All the children but the youngest attend school and kindergarten. The atmosphere of this home suggests that even among Italians quiet and patient training brings the desired results. These children are "good", under excellent discipline, and yet alert, normal, and active. No neurotic traits present themselves. The children play happily together and voluntarily help their mother with the housework. She is a gentle type of woman who does not correct them in a noisy fashion. She is a hard worker, scrubs the bare floor every day, and keeps the house as presentable as possible. The children are a real help to her of their own free will. This was the only home in which an atmosphere of this sort was found.

Case 12.—The L— family live in squalid conditions in three dark, dingy rooms, devoid of sunshine or ventilation. The father is a laborer. There are four children—seven, five, three, and one. The oldest masturbates frequently and is mentally retarded. The mother is resigned to the situation and no attention is paid to the child's habits.

Case 13.—M— is a tailor by trade, living in a comfortable four-room flat. The children range in age from ten years to two days. Emily, the eldest, a thin, owllike child with big glasses and a self-righteous bearing, is a chronic tale-bearer, which accomplishment raises her to a high place in the esteem of her parents. She only too readily launches forth into an enthusiastic rehearsal of the misdemeanors of her "fresh" brothers and sisters. She is a pale, anæmic-looking girl, undernourished and restless. Every one "picks on her"—with good reason. "The boys steal her pencils at school, and she tells on them and the teacher hits them." She constantly twists the buttons of her sweater between her long, thin fingers, she bites her nails, and she is a bed-wetter. She gives a history of having had a vaginal discharge a year ago and sore eyes. Her strong suit is "squealing on" the others to her parents, and she finds plenty to squeal about. When she squeals, her parents belabor the offender whose sins she discloses while she sits by a paragon of virtue, and gets off scot free. She usually tells tales on Remus because he punches her. Then Remus receives a parental punching which incites him again to punch the tattle-tale, and so the vicious circle goes. Emily is a noncombatant herself, knowing that if she fights, she will get not only worsted, but "squealed on", and then her father will hit her. She gets her satisfaction indirectly, with safety to herself, whereas Remus does his own pummeling and suffers the consequences unflinchingly. He is a wide-awake, attractive boy of six years. He not only is an untiring fighter and given to tantrums, but he talks in his sleep. He is "a fresh boy at home, but he be's a good boy at school".

His sister, eight years of age, stayed in one class two years. "She was always afraid teacher would hit her if she was absent. She doesn't want to do no work and mother hits her." A visiting neighbor observed: "Believe me, they have a good mother. She lets them have all their own way and that doesn't pay." The mother has absolutely no influence over this family.

Julia, aged four and a half, has a finicky appetite, and bites the others. She is irrepressible and self-conscious,

tends to be dramatic, makes silly faces, and is full of spirit and fun; her father calls her "crazy".

The boy of three years picks his nose continually, is a mouth-breather, and has adenoids.

All of these children are said to be timid if any one knocks at the door, and they run away from a chicken in a panic of fear!

Case 14.—Mr. and Mrs. N— and their two children of two and three years live in a spotless flat under good economic conditions. The little girls are perfect specimens physically. The older one is "nervous". "If she don't get her own way, she gets awful bad!" She consequently always manages to have her own way in everything and is never crossed or disciplined. The demoralizing factor is an indulgent grandmother with whom this child sleeps and who grants her every wish. The younger child "is never any trouble". "She sleeps with her mother and doesn't get everything she wants."

Case 15.—The O— family consists of father, mother, and three children. The father is a noisy, bombastic individual, excessively talkative and high-strung, always ordering his family about. He is egotistical, feels his importance and responsibility, and keeps everything in an uproar. His wife remarked drearily: "Isn't he something awful? He's like this all the time when he's home. He talks all the time and makes me nervous." The oldest child, a girl of eight years, grits her teeth at night. The boy, aged four, twitches his eyes, has "terrible tantrums", is "backward", a mouth-breather, and has adenoids. "If he don't have things his own way, it's wicked around here. He's spoiled!"

Case 16.—The P— family is an illustration of a household in which the mother is an ineffectual, negative sort of individual, a helpless type. The children are utterly undisciplined and there is constant confusion. There are six of them in all, ranging from ten years to eight months. The ten-year-old bites her nails, and the eight-year-old boy hits the others, swears, and calls them all "blind". He fights continually and misbehaves in school.

The seven-year-old boy has been two years in one grade.

Case 17.—The Q— family live in three rooms under fairly good economic conditions. The father is a longshoreman. Of the three children, aged six, four, and two years, two are strong, but the four-year-old boy has been ill from infancy. He had a difficult instrumental birth, and at nine months began to have convulsions. These have increased steadily in severity and frequency, and at present he often has seizures of several hours duration and many slight ones, both day and night. He has had no other illnesses, but is developing an unusually slow pulse and an interesting heart condition. He is given solicitous care and is never disciplined. He is pale, thin, and restless, and shows many neurotic traits. He runs away whenever he gets a chance, and will not obey his parents or answer when spoken to. He is mischievous and has a violent temper. He bites his nails, picks his nose, grinds his teeth, and masturbates. He is constipated and has difficult urination with flushing of the face, and is losing weight. He has never talked plainly.

Case 18.—Mr. R—, an Italian laborer, has six children, ranging from ten years to ten months. They are all "nervous", and their maternal grandmother and aunt have been insane. All of these children have been slow in developing; none has talked before two and a half years. One has been in one class two years at school. The three aged five, three, and two are "always wet". The two-year-old also soils himself. He is a restless sleeper, and rickety and bow-legged. He "eats all the time", goes from house to house—his aunt's, grandmother's, etc., nearby—and is fed all day long by well-meaning relatives. As regards masturbation, the aunt said: "They all do it, you know. You can't watch them. We holler at them."

Three weeks ago, the five-year-old child set herself on fire with a candle and was seriously burned. The mother, believing that the child would surely die, was frantic with grief; she developed delusions, refused to eat, and finally became maniacal and had to be committed to a hospital for mental disease, where she died within two weeks. Some of these children will probably be placed in institutions.

Case 19.—Alexander S—, a boy of nineteen years, illustrates the effect of lack of training. His mother is an excitable woman with a hot temper. Alexander was the first child and was from infancy "nervous and irritable". He "cried easily and wanted everything his own way". He was threatened and shrieked at, but was not controlled. (Babies are too often at first petted excessively and "spoiled" in every conceivable way, and then beaten and ineffectually scolded throughout later childhood. Many parents seem to know no other method of discipline.) Alexander attended school as far as the eighth grade; then refused to finish because, as he explains, "he thought he was a man and wanted to go to work". Now he shows lack of ambition, is lazy, and usually out of a job. His mother says he refuses to work and has a bad temper. He has never learned to make an effort to apply himself to anything long or to feel any degree of responsibility.

Case 20.—The T— family consists of father, mother, and three children, the eldest a girl of nine years and the youngest a seven-months baby one week old. They live in four rooms, and the house is neat and clean. The father is a blacksmith, but is out of work. His manner toward his wife is sullen, vindictive, and domineering. When she started to tell about her fall, which brought on this confinement, he ordered her to "shut up", in a suspicious fashion. He later began to talk about himself and said that he had returned six months ago from the Psychopathic Hospital, where he had been a patient for eighteen months. He had previously been out of work for several months, had started to loaf and worry, and then had lost his mind. He became violent, broke up the furniture and china, and beat his wife and children. His wife is thin, pale, haggard, and anxious. He never leaves the room when visitors come to investigate this home. The oldest child shows neurotic symptoms and is pale and undernourished. She has had diphtheria, scarlet fever, and operations on her ear and throat. She is in the third grade at school and is morbidly anxious to be on time, to such an extent that every night she changes her clothes and puts on clean ones in which she sleeps, in

order to be punctual the following morning. She is finicky about her food and excessively fussy. The four-year-old boy had convulsions three times a year ago.

If the father wishes to enforce obedience from his children, he raises a chair and threatens to hit them over the head with it, and would probably carry out this threat. His tone, when he speaks of his wife, is one of contempt and hatred. The wife is ignorant and uncoöperative and refuses to allow her husband to be placed in an institution.

Case 21.—The U— family consists of four girls and one boy, ranging from nine years to four months. The eldest is "nervous", bites her nails, talks in her sleep, and picks her nose. Both she and her eight-year-old sister have been two years in one grade at school.

The next two children are bed-wetters and have incontinence of urine in the daytime as well. No effort is made to correct these conditions.

Case 22.—The V— family live under fairly good conditions. The father is a chauffeur. There are five living children, aged twelve, seven, six, four years, and two months. Of these the seven-year-old girl has incontinence of urine. The six-year-old boy is called "fresh", which means that he is mischievous and uncontrolled and annoys the other children. He picks his lips and nose, sucks his thumb, and is a mouth-breather. He does not talk plainly. The four-year-old girl also picks her nose a great deal of the time. These neurotic trends are blandly taken for granted. Occasionally spasmodic efforts are made to correct them. The children are slapped or screamed at, but it is not expected that they will obey, and they simply become more rebellious and nervous in consequence of such ignorant measures.

Case 23.—The W— family live under very crowded conditions. Alice, Emily, Julia, and Thomas, aged ten, eight, seven, and five, sleep in one bed. Thomas is bright mentally and talks well, but cannot walk and has hydrocephalus. He had meningitis when six months old. Emily has tantrums, screams, and hits the others. The sixteen-months-old child is deformed from rickets.

Case 24.—The X— family live under poor economic conditions. There are five children. The fourteen-year-old girl sleeps in the same bed with her brothers, aged eight and five years. Two of the children are cross-eyed and one is "nervous". He is a mouth-breather and cannot talk plainly. He keeps his fingers in his mouth, and he scratches and swears on the slightest provocation.

Case 25.—Emily Y—, aged two years, is a neurotic child. She sleeps poorly, and has incontinence of urine. She has a finicky appetite, picks her nose and her fingers, and has frequent outbursts of temper, when she lies on the floor and kicks and tears her hair. Her mother meets this condition as it is usually met, not by trying to understand the child, but by soundly spanking her, flying into a passion herself.

Case 26.—The Z— family illustrates the effects that ignorant methods of disciplining have upon children. Mr. and Mrs. Z— have eight children, ranging from fifteen years to five months. The fifteen-year-old boy still suffers from bed-wetting, the five-year-old bites her nails, and the three-year-old keeps her thumb in her mouth. She frequently attacks her older sister with the butcher knife. Then the mother screams at them and threatens to take them to the hospital.

The sixteen-year-old daughter recently ran off and married a man much older than she. Her explanation of this is that from early childhood her mother beat her and never allowed her to go out. She does not want to see her mother any more and does not speak to her, but is sorry to leave her father, who cries every day because she refuses to come home.

Case 27.—A— B— has seven children. They live closely crowded, under poor hygienic conditions. The father has been away from work for two months, because of an injury to his back, and the family expenses have been met by the overseers of the poor.

The eldest child, a girl of twelve years, has always been "nervous" and anæmic. She is constantly complaining of pains in various parts of her body, especially severe headaches which are not relieved by glasses. She has remained two

years in one grade in school. She is constipated and has a finicky appetite and a bad temper. She cries easily upon little or no apparent provocation, twitches her eyes, and bites her nails, and her sleep is disturbed by distressing dreams that she is sick, is falling down from a great height, etc. The boy of thirteen also frequently twitches his eyes and is constipated.

A younger brother, aged ten, has, like his elder sister, remained two years in one class.

One other child talks in her sleep, and one is cross-eyed and wets and soils himself.

Case 28.—C— lives with his wife and five children in three small, dirty rooms. The wife is subnormal mentally. She is unable to tell what grades her children are in, saying, by way of excuse, that she "forgets everything they say". She says she "gets so nervous" she'd "like to kill them", and gets "so mad at times that she faints". The children "fight like cats and dogs"—especially W—, aged nine. Her mother, enraged, hits her on the head with a stove brush. This child cannot speak plainly, still wets her bed, and talks in her sleep, as does her younger sister, aged eight. The five-year-old is "nervous and cranky". "If she wants something and doesn't get it, she cries the whole day long." The mother shrieks at the children intermittently, "Stop! This lady'll hit you!" One of the children in this household died at thirteen months of convulsions, and the youngest, aged nine months, is restless and twitches in her sleep.

Case 29.—C— D—, aged seven, is cross-eyed and has failed to be promoted in school because he "could not learn".

Case 30.—E—, aged four years, cannot speak beyond saying "mama". He has had seven operations on neck, throat, ear, and spine. He is not defective mentally, but is "nervous", "must have his own way", and is subject to temper tantrums.

Case 31.—Mrs. F— complains that her boy of four is "fresh" and uncontrollable. He is saucy and has outbursts of

temper in which he bites and kicks people. He is a mouth-breather and bites his nails. His mother exclaimed: "Another woman would have killed this kid long ago. *I hit him terrible!* He deserves to be killed! He can't stay still. He's got to be doing something. He breaks the furniture and everything." Not only is this boy uncontrolled, irrepressible, fidgety, and inquisitive, but his sister, aged two, is likewise getting "fresh". The father is "awfully hot-headed" and does not answer when spoken to, if irritated. His wife is "nervous" and explosive.

Case 32.—The G— family live under good economic conditions, in four rooms. The mother is a good housekeeper. There are six children, ranging from nine years to thirteen months. This home shows the most normal atmosphere of any yet visited. The mother attributes the good behavior of the children to the fact that she herself is not nervous and does not lose her temper or beat the children. She has observed that in homes in which the parents bully their children there is always less obedience. Also, she never represses the children's play life. They amuse themselves well, and when she goes out, she leaves them playing school together and they never make any trouble. They are bright, alert children, full of initiative and imagination. The hygiene of the home is better than is often found. The three oldest girls sleep together in one room, and the two smallest have separate beds in their parents' room. One child is cross-eyed, and the mother is careful to see that she wears her glasses to correct this. Three of the children attend school. One was given a prize for having dental work that had been advised by the school physician done promptly. These children are free from neurotic trends.

Case 33.—H— is an only child of four years, much pampered and spoiled. The home conditions are poor, two families sharing four untidy rooms. The child's father, a laborer, has been out of work for two months. The child's mother is said to be high-strung and to have a hot temper. The little girl is never still. She is fidgety and restless and irrepressible. No one has any control over her. When not

given her own way, she flies into a fit of anger, lies on the floor, kicks, screams, bites and scratches, and tears her hair. The doctor has advised them not to notice her, but just to let her have her own way, and predicts that when she is ten years old, this condition will clear up! This child has a capricious appetite and, never being disciplined or trained, she is consequently underfed and undernourished. She runs away constantly, and she both soils and wets herself by day and by night.

Case 34.—Mrs. I— is a high-strung, nervous little woman, a widow, who lives with her three children in a tenement of three rooms. The older children, aged eight and five, are "no trouble", but the three-year-old girl "drives her mother crazy" because of her tantrums and her restlessness. Yet when this child is away from home, she is invariably well-behaved and obedient. In the day nursery she is a model child, and when she was sent away to the country last summer, she gained weight and had perfect health. At home she presents a very different picture. She is undernourished, excitable, and uncontrolled. She "shivers" and twitches her eyes. At times she is said to have "convulsions with fever". She continually bites her nails and picks at her nose and lips. When she goes to sleep, she does so with the lace curtains between her teeth. She sleeps with her mother because she refuses to sleep alone. She comes as near to perpetual motion as one could find anywhere; it seems impossible for her to stay still. She grabs things away from the other children, then plays with the toys for a brief time, but shortly destroys them, tearing them to bits. She opens the icebox, throwing the food out on the floor. "When she's got to do it, she's got to do it." She lies on the floor, kicks and screams, and chews bits of string, pulling them back and forth between her teeth. "Her mother licks her", said her aunt, "but it makes her worse." The distracted, thin, frail mother is at her wits' end with this child, failing to understand her or her needs. If she tries to do her ironing, the child in a rebellious temper snatches away the clothes, clings to her dress, and makes a disturbance in every conceivable way. "Her mother punishes her every minute—*she's got to.* Then she tries petting

her, but nothing does any good." Gentle firmness she has no conception of. The child is absolutely untrained and still wets her bed. Much of her nervousness has been attributed to her adenoids and tonsils, which should be removed. The delicate and baffled mother is constantly begging various agencies to place this child for her, her one solution seeming to be to get the girl adopted and thus disposed of.

Case 35.—J—, aged two years, jumps whenever he is spoken to. His mother excuses his nervousness by saying, "He wants everything his own way. He is the first child, and they are always spoiled, you know." He has a finicky appetite and is much underweight. He bites his nails, picks his nose, and has tantrums on the slightest provocation. He wets himself continually and is a restless sleeper, often crying out through the night.

Case 36.—K—, an American child of four years, is an illustration of what wise training accomplishes in a nervous child. This child bites her nails occasionally, has a finicky appetite, and talks in her sleep if she has been the least excited before going to bed. She used to have frequent severe tantrums. At first the mother would lose her temper and fly off the handle, she says; whereupon she found that the child got just like *her,* and matters went from bad to worse. This mother found that by coaxing the child, and diverting her attention, she had no difficulty in controlling her. Though naturally a nervous, high-strung woman, she has worked out this method herself and has adhered to it. The child now goes to kindergarten and is one of the brightest and best trained of the children. She learns quickly and seldom has to be corrected or spoken to.

Case 37.—Elsie L—, aged four and a half, is a neurotic child. She picks her nose, bites her lips, and picks at things with her restless fingers, and twitches her arms and legs occasionally. She is a finicky eater, and refuses to go outdoors and play, preferring to sit near the stove with her dolls. She is a dreamy, preoccupied, sensitive child who does not answer when spoken to, a case in need of special supervision and

care. She is a restless sleeper, jumps, twitches, and talks in her sleep. She wets her bed, and a doctor, consulted casually, remarked that it was her kidneys and advised that they be kept warm. This nervous child is attending school, and no one has given her physical or nervous condition the consideration it demands.

Case 38.—Mrs. M— is a very nervous, sensitive woman. She has four children, aged seven, six, four years, and eight months. The boy of six years is likewise "nervous", and twitches. He talks in his sleep, and has mad outbursts of temper. The four-year-old girl is very much like him, and in addition she wets herself and is excessively shy. All three children bite their nails and pick their noses and lips.

Case 39.—In one kindergarten visited, fourteen children were present out of an enrollment of forty. Of these fourteen, three showed marked neurotic trends. One, a boy of four, when first brought to school, was restless and intractable; he rocked back and forth constantly, and screamed a large part of the time for two or three days. His father brought him each day, and roughly "yanked him about and cuffed him". After three days, under a different type of treatment, this child became quiet and happy.

Another boy of four years is reported to be dreamy and inattentive and listless. He follows his brother about and imitates everything he does.

One child, five years of age, the teachers say is "spoiled". He will not listen, is disobedient and indifferent. He is subject to frequent outbursts of temper and no method of discipline seems effectual except terrifying and bullying him, the procedure to which he is accustomed at home.

Case 40.—There are seven children in the N— family. Four of the seven are nervous, three of them bite their nails or lips a large part of the time, one cries out in her sleep, and the boy of twelve is "fresh" and continually fighting with the rest.

Case 41.—Mrs. O— is a mild, ineffectual, gentle sort of woman who has little influence over her seven children. Her

husband, on the contrary, is intelligent and coöperative. The boy and girl of four and five years do not yet talk plainly, and the girl of eight years still wets herself both during the day and night. The teacher meets this condition by sending the child home from school as a method of punishment, and in consequence she has remained two years in one class. The father willingly consents to take the child to a nervous clinic for examination and advice, and welcomes assistance of any kind.

Case 42.—There are eleven children in the P— family. The eldest, a girl of seventeen years, has recently had an illegitimate child. The father threatened to kill her if she returned home from the hospital with the baby, so she parted with the infant, though fond of it. Nine of her ten brothers and sisters (including three boys of fifteen, thirteen, and eleven years) still wet themselves. All five of the boys and the little girl of four have violent tantrums. The little girl "cries for everything and gets it". "She dances about, trembles from head to foot, lies down on the floor, and shrieks." She also sighs and walks in her sleep. The fifteen-year-old boy is the special despair of his mother. He has reached only the fifth grade in school, and his mother says she "wants to put him away for she thinks there is something wrong with him". "The more she whips him, the worse he behaves." His oldest sister also was two years in one class, and left school at the age of fourteen when she had reached the seventh grade. All the children pick their noses and bite their lips and nails.

Case 43.—The Q— family history is a tragic one. Mrs. Q— went to work in Italy when but eight years of age. Her mother had died three years before this, and her father was alcoholic and abusive. Mrs. Q— has had a family of seven children, ranging at present from nine years to six weeks in age. She has lost three of the seven. Two of them, boys of one and two years, were *feebleminded*. A girl of six is feebleminded and is at present in an institution. The girl of four years shows marked deformity from rickets, and is a mouth-breather. She also is probably subnormal mentally. But one

child, a girl aged eight, is bright and normal and doing well in the second grade in school.

Case 44.—Annie R— is eighteen months old and an illegitimate child. She is intensely nervous. Her mother, in desperation, "threatens to kill her twice a day". The baby wets herself day and night, sighs in her sleep, and possibly has slight convulsions. Her hand is never out of her mouth; she is constantly chewing it. She has many tantrums every day. She shivers from head to foot and holds her breath until she is blue and exhausted.

Case 45.—Mrs. S— is epileptic and "gets mad and beats her four children". She is much of the time out on the streets, leaving the house locked and the child of five in charge of the two younger ones. The oldest of the four, a boy of six years, has been two years in one grade "because he wets himself". This is not the actual reason, for he is mentally retarded, is slow to answer, and does not yet speak clearly. He is a finicky eater, and thin and undernourished. His five-year-old sister sleeps poorly and has had convulsions. These children are under the care of an utterly irresponsible mother.

Case 46.—Mrs. T— is the mother of eleven children. She is mentally subnormal. Her husband, a longshoreman, is a steady worker as a rule, but owing to present economic conditions has been out of work all this winter and last.

The boy next to the oldest, aged seventeen years, is deaf and dumb and mentally deficient. He is in an institution for the feebleminded, but comes home on occasional visits. He behaves well for a time, but after a few days gives way to outbursts of temper, and threatens the life of his parents. It becomes necessary to call in the police, and it takes three or four men to control him. Despite this fact, the mother regrets that he is not at home permanently. He is especially sullen because he is not given all the money he wants. Several of the other children show nervous and mental abnormalities. Three of them have been two years in one grade at school; one has been repeatedly punished for truancy. The boy of eleven is a mouth-breather; the girl of seven wets herself both night and day, and twitches her eyes; the little five-

year-old girl did not talk until four years of age and has marked facial asymmetry; and the boy of two years has convulsions.

Case 47.—Mrs. U—, a woman of thirty years, is subject to frequent hysterical episodes. She has had six children, three of whom are living. She divorced her first husband and subsequently had an illegitimate child, now five years of age. Two years ago she married a second time.

The five-year-old child talks in her sleep, and an older girl, aged seven years, remained two years in one class.

This woman spends a great part of her time in bed. She is torn by mental conflicts of a religious nature, and lives in constant fear that the end of the world is impending. She has labored for some time under a delusion that she is pregnant and two months overdue.

Case 48.—Mrs. V— is an excitable, high-strung American woman. She lives under poor economic conditions, is a widow, and supports her two children by working in a factory. The older child, aged four, is diffident and seclusive. She talks and plays spasmodically, and shows little interest in the other children in the day nursery. She is not a good mixer except with grown-ups, is stubborn, lacking in energy, and refuses to attend kindergarten.

The younger child, aged one year, does not try to walk, has a finicky appetite, and wets herself. She was brought to the day nursery, but cried continually for three days, and has since then been kept at home under the care of the grandmother.

Case 49.—Mrs. W—, a nervous high-strung little American woman, brought her three children, aged four years, two years, and seven months, to the clinic. She states that they drive her wild; she cannot control them, and frequently is so nervous that she does not know what to do and is obsessed with the desire to throw them all out of the window.

The oldest, a boy of four, is clumsy and always falling down. She has no control over him. He has frequent outbursts of temper. He bites his nails, picks his nose, and masturbates.

The next child is a puny, pale, tiny girl of two years, markedly undernourished. She has a finicky appetite and an

irascible temper. She sleeps poorly, wets herself, bites her nails, and masturbates. She does not yet talk. Her brother is sturdy and strong, is always picking on her and teasing her.

The baby also is undernourished.

In a series of 190 children the following conditions were found:

1. *Speech defects*	
Baby talk	10
Stuttering	1
Late in talking	4
Mutism	2
2. *Motor habits, incoördination, and convulsive manifestations*	
Fidgetiness and choreiform movements	13
Twitching of eyes and face	7
Shivering	2
3. *Incontinence, etc.*	
Bed wetting	49
Incontinence by day	27
Soiling	9
Difficult micturition	1
4. *Conduct defects*	
Holding of breath	1
Tantrums	52
Spoiled child (stubborn, difficult, uncontrolled)	41
Excessive boldness	11
Excessive timidity and shyness	13
Excessive finickiness and precision	1
Running away	3
Truancy	2
Pilfering	1
Biting and scratching others	5
Seclusiveness	6
5. *Sleep disturbances*	
Restless sleep	12
Disturbing dreams	7
Sleep walking	1
Crying out in sleep	6
Sighing in sleep	2
Talking in sleep	11
6. *Mental habits and mental grades*	
Mentally retarded or defective	13
In one grade two years	18
Given to daydreaming and fantasying	3
Preoccupied and absent-minded	4
Epilepsy	3
Idiocy	4
Mentally deficient, epileptic, or psychotic parents	18

7. *Miscellaneous*

Capricious appetite	17
Headaches	2
Imitativeness (excessive)	1
Masturbation	12
Thumb and finger sucking	10
Nail biting	33
Picking of nose, lips, and fingers	26
Gritting of teeth	3
Strabismus	10
Excessive jealousy	2
Hydrocephalus	2

Difficulties in personal balance, if not mental problems, sometimes express themselves in various substitutive forms. In some cases such difficulties are at the basis of alcoholism. As illustrative of the actual situations in which alcoholism plays an important part, the following cases are cited:

Sex	Age	Economic condition of home	Heredity	Other data
G.	14	Poor, dirty, and overcrowded.	Parents ex-alcoholic. Father lazy. Mother "a chronic beggar". Brother feebleminded and delinquent. Two sisters delinquent, one living at home with two illegitimate children.	Feebleminded and immoral (mental age 8 years; I.Q. 57). Mother refuses to place child in institution.
G.	14	Filthy. Hygiene poor. Improper and insufficient food.	Father and stepmother alcoholic and abusive. Children 14–10, bed-wetters.	School record very poor. Unhappy and overworked at home.
B.	12	Poor.	Father alcoholic; court record (stealing, nonsupport, assault and battery). Mother abusive. Maternal grandparents alcoholic. One maternal aunt epileptic and two mentally deficient.	Mentally retarded (mental age 8 10-12; I. Q. 68). Nervous, disobedient, seclusive, timid, and irritable. Bad company.
G.	18		Father alcoholic. Stepmother immoral, and mother reputed to have been.	Mentally retarded (mental age 10 6–12; I. Q. 66). Syphilitic. Sex delinquent. Industrious factory worker.
G.	17	Home filthy during mother's life. Improved recently.	Father colored, alcoholic. Mother, French Canadian, died recently; was abusive and immoral. Family mentally subnormal. One child stutters. All stubborn and unmanageable.	Mentally retarded. Speech defect. Truancy.

The total number of juvenile delinquents placed on probation last year in the probation court for all Boston was 849. Of these 107 came from the district under consideration.

In 1921, the S. P. C. C. handled 100 cases living in the district studied out of a total of 1,507 cases in all Suffolk County.

Such cases as the following may be mentioned in an ordinary sociological or economic review, but tend to receive little attention from the point of view of the basal psychological factors:

Sex	Age	Economic condition of home	Heredity	Other data
B.	13	Child boarded out in objectionable homes.	Parents separated. Father tuberculous. Mother served term in house of correction.	Feebleminded (mental age 8 4–12; I. Q. 62). Has sold papers from 9 years of age. Sensitive, bed-wetter, tantrums. Runs away from foster homes.
G.	15	Good.	Father dead (tuberculosis). Mother rigid disciplinarian.	Repeated truancy (mental age 13 7–12; I. Q. 87). Pathetic, tired, unhappy. Ran away from home.
B.	9	Good.	Others of family normal.	Retarded in school (mental age 8; I. Q. 83). Truant and runaway since 3rd year. Lying, pilfering, and bad companions. Masturbator. Seclusive, irritable, timid.
G.	15	Home atmosphere intolerable.	Father severe and abusive. Mother mentally abnormal. Brutal and bites child. Two children have run away. One deserted her family and is immoral.	Mentally retarded (mental age 11 9–12; I. Q. 76). Sex delinquencies.
G.	22		Unmarried, feebleminded mother.	Mentally retarded (mental age 11 5–12; I. Q. 71). Tuberculous. Sex delinquent (has illegitimate child). Prevaricator. Industrially inefficient.
B.	15	Dirty and overcrowded. Father and two boys share one bed; four girls share the other.	Father, widower, neglects and abuses children. Two mentally retarded. Boy, aged 13, delinquent (truancy, runaway, pilfering, breaking and entering, etc.).	Wayward boy. (Delinquencies: truancy, runaway, pilfering.) Refuses to attend school or go to work.

The following cases exemplify poor economic environments for children, probably determined by essentially mental factors—inefficiency, instability, or other qualities in the parents:

Sex	Age	Economic condition of home	Heredity	Other data
G.	2	Poor, but clean.	Father unstable; deserted and arrested for nonsupport. Mother poorly balanced and abusive.	Child has been boarded out; is poorly cared for and afraid of foster mother.
B.	12	Poor, dirty. Children insufficiently clothed.	Father poor provider. Mother brutal. Both parents quarrelsome and abusive. Brother delinquent.	Misdemeanors: truancy, staying out all night. Bad companions. Inveterate smoking.
B.	2	Very poor, but clean. Father scissors grinder. Lazy, erratic about work, contributes 50–60 cents a week toward support of home.	Father irritable, threatens to kill wife, terrifies children. Three paternal uncles eccentric.	Mentally retarded, uncontrolled temper. Poor physique.
B.	5	Poor. Father organ grinder. Irregular work. Income 60–75 cents a day.	Father abusive. Mother epileptic. Eight children, oldest slow to develop. Two truants.	Puny child. Unruly and uncontrolled. Bites his mother. Keeps family awake at night.

The following cases are examples of homes in which one or both parents are suffering from abnormal mental conditions (mental defect or instability):

Sex	Age	Economic condition of home	Heredity	Other data
G.	11	Mother unable to support self and child without aid.	Father died of general paralysis. Mother feebleminded and syphilitic. (Mental age 8 11–12.) One child, five miscarriages.	Mentally retarded (mental age 9 11–12.) Unsupervised, untruthful, self-willed.
B.	6	Good.	Mother mentally unstable when pregnant. Destructive and violent.	Mentally retarded (mental age 5 10–12). Overactive and stubborn.
B. B. B. B. B. G.	10 8 6 5 2 2	Poor. Father refuses to work more than half time.	Father mentally deficient. Married to his niece. Mother feebleminded and syphilitic. (Mental age 8 1–2.)	Six children feebleminded; four in institutions.

While this report is in no sense statistical or exhaustive, it brings forward facts of great social and economic importance. Do not such findings as the above point to the need for a well-thought-out organization of the community resources for the promotion of physical and mental health? Among the steps to be taken immediately would be: (1) the establishment of mental-hygiene clinics; (2) the instruction of social workers, nurses, and parents in the simple principles of child training; (3) better recreational facilities and community supervision of the juvenile population.

CHILD MENTAL HYGIENE IN ERIE COUNTY, NEW YORK

AARON J. ROSANOFF, M.D.

Clinical Director, Kings Park State Hospital, Kings Park, New York

FOREWORD BY THE NATIONAL CHILD HEALTH COUNCIL.

Seven national and two state organizations, through the National Child Health Council, undertook a coöperative inquiry into child-health conditions in the rural sections and villages of Erie County, New York, during the two weeks ending December 12, 1921. This inquiry resulted from the invitation of many leading representatives of Erie County.

A most valuable contribution to this study was the information collected and the recommendations made by Dr. Aaron J. Rosanoff, who represented The National Committee for Mental Hygiene. The section on mental hygiene of the joint report was necessarily limited to data relating directly or indirectly to the rural sections and villages of the county. Therefore, the council has welcomed the independent elaboration of this section by Dr. Rosanoff, who has added other data collected by him for the entire county, including Buffalo and other cities in the county.

The National Child Health Council takes pleasure in inviting attention to this independent and more complete review of the problem of the mental health of children in Erie County as an especially worth-while contribution.

THE main purpose of this survey has been to bring to light conditions in the rural parts of Erie County pertaining to the mental hygiene of childhood. The following circumstances, however, have led to the inclusion of a consideration of facilities available in the city of Buffalo:

The total population of Erie County is 634,688 (Fourteenth United States Census, 1920). Of this total, 506,775, or 79.8 per cent, live in Buffalo. Between 85.0 and 87.5 per cent of all taxes gathered in Erie County are paid by residents of Buffalo.

Of the 127,913 residents of Erie County outside of Buffalo, no fewer than 83,710 live in the suburbs of Buffalo, for the most part within a single-trolley-fare ride. This includes the cities of Lackawanna and Tonawanda and the townships of Amherst, Cheektowaga, East Hamburg, Hamburg, Lancaster, Tonawanda, and West Seneca. The remaining 44,203 of the

population of the county are living in rural areas spread over nearly eight hundred square miles.

Even the institutions and organizations financed by the county as a whole, and not by the city of Buffalo alone, make the center of their activities in the city. Moreover, the agencies belonging to the city of Buffalo often extend their services to the rural population. Thus the city department of health does considerable bacteriological work for health officers throughout the county, makes examinations of blood, spinal fluid, and the like; the department of hospitals and dispensaries treats in its health centers and hospitals patients brought in from rural parts of the county; and occasionally a mentally defective child from a rural part of the county is placed with relatives or friends in Buffalo in order to provide for his training in a special class for atypical children in one of the city schools.

The officials and other citizens of Buffalo are accustomed to this situation. Those with whom we have conferred have invariably pointed out that a sharp separation of public activities of the city from those of the county would not be practicable and is not to be insisted upon.

This report consists of three parts. The first gives a description of county, state, city, semi-private, and private agencies within the county that have to do with child mental hygiene; the second gives an enumeration of agencies outside of Erie County that render service to children whose homes are in that county; and the third contains recommendations for such coördination of the work of existing agencies and creation of new agencies as might result in economy of labor, through avoidance of duplication, together with increase and improvement of service.

Agencies Existing Within the County

1. The *department of education* of the city of Buffalo has special provision for work with atypical children. Such work was begun in 1910, at which time there were no special classes in the Buffalo schools. Now the department conducts twenty-five such classes. At the head is a physician who has specialized in applied psychology. He occupies one of the offices of

the department in the New York Telephone Building and has two psychological assistants to help him in the work.

Children requiring psychiatric examination are referred either to the out-patient mental clinic of the Buffalo State Hospital, or to the city department of health, or to the department of hospitals and dispensaries.

It is estimated that the pupils now provided for in special classes, about 400 in number, constitute but one-third of those for whom such provision is needed. There is considerable resistance on the part of city officials, parents, and others to the establishment of special classes for atypical children and to the transfer of children to such classes. Special classes entail increased expenditure. The transfer of children to them is often objected to on the grounds that it places, at times unjustly, a permanent stigma on the child, deprives it of normal and beneficial associations, and is sometimes made in cases of normal children, hastily classified as defective merely because of a poor showing in an intelligence test or because of uninvestigated and unexplained retardation. In some instances the transfer of a pupil even to a special class for supernormals is objected to, because that, too, breaks up established associations and might force the child's ambitions and efforts beyond the limits of its capacity.

Within the department of education it is felt that these objections are relevant only in so far as the system may be abused or carelessly conducted and are based rather on fears of such abuse than on its actual occurrence. Occasional errors are probably made, and cases are cited of children who had been placed in special classes and have since eminently made good. These cases are held by some to illustrate the advantage of special classes, and by others to prove that children of good capacity are sometimes erroneously classified as defective.

The department of education considers, of course, not alone the interests of atypical children. Its advocacy of special classes is based partly on the fact that the whole school system is benefited by them through specialization of effort and simplification of problems. In the course of this survey teachers who have one or more atypical children in their classes have repeatedly reported to the investigator that these

few children occupy one-third of their time, disorganize discipline, and handicap the work with other children.

Perhaps the only true disadvantage of special classes is the sentimental one arising from the humiliation involved in the classification of a child as mentally defective. This is a sentiment that should be respected. In the past it has been needlessly irritated by the gratuitous use of derogatory expressions. There is no reason why such medical diagnoses as mental deficiency, psychopathic personality, and the like should be used in the official and published language of educational authorities with reference to any child or group of children. It is proper to speak of special classes, and in such designation should be included not only classes for mentally atypical children, but also those for the blind, deaf, crippled, tuberculous, supernormal, perhaps the "muscle-minded", and those possessing special aptitudes. It may be that, as children in the schools receive more individual attention and the work is more nicely adjusted to their special needs and capacities, a time will come when most of them will be taught in special classes of one kind or another. In that event, whatever stigma now attaches to special classes may be removed.

In connection with atypical children in the schools, a need is felt for psychiatric social workers to make home investigations and studies of family and personal histories. In some instances teachers have been detailed to do such work.

In general it would seem that the mental-hygiene activities of the Buffalo city schools are in competent hands and have made splendid progress since their organization. The educational authorities are handicapped by lack of funds and room for a complete system of special classes, lack of an adequate personnel trained for making group and individual psychometric tests and for teaching special classes, practically entire lack of psychiatric social workers, and imperfect availability of the services of a psychiatrist.

As regards the last item, it should be added that just as resistance is encountered when it is proposed to transfer a child to a special class, so there is even greater resistance when it is suggested by school authorities that a child should be sent to one of the out-patient clinics of the Buffalo State

Hospital for examination on account of suspected mental trouble.

The amount of psychiatric work there is to be done in the Buffalo schools is sufficient to justify the employment of a whole-time psychiatrist. *It should be possible to refer a child for psychiatric examination without its being taken out of the physical plant of the department of education, perhaps even without its being taken out of its own school building.*

2. In the *schools outside of the city of Buffalo* mental-hygiene activities have made little progress as yet. In the cities and larger villages with good-sized schools the authorities are attempting to make special provision for atypical children.

Among the schools visited one in Hamburg is especially noteworthy. One of its teachers has displayed an unusual interest in mental hygiene and, with the support of the principal, has equipped herself by taking special courses in psychometric work and work with atypical children. Although this school had no special class, the children who present special problems had been singled out and given a great amount of individual attention, which is even better.

In this school were found, as elsewhere, the usual handicaps of lack of room, of funds, and of an adequate personnel trained for such work.

In those parts of the county in which there are only small ungraded schools there is no such thing as mental-hygiene work. As might have been expected, in practically every schoolroom visited one or more extremely backward, troublesome, delinquent, or otherwise mentally abnormal children were found. It would be impossible to make other than a general estimate of how many additional atypical children might be discovered upon thorough investigation.

In this connection two points should be emphasized:

(a) The Lockwood Law, which provides that any school district that has ten or more markedly retarded children shall establish a special class for them, often remains a dead letter. This is because practically nowhere in the county has the exact number of atypical children for whom special classes should be provided been scientifically determined. A thorough

survey would undoubtedly reveal many school districts with ten or more such children, either in the school or in their homes. In no other way can a basis for the enforcement of the Lockwood Law in rural districts be established.

Answers to a questionnaire that was sent to all the schools reported a total of 192 children, or 1.7 per cent of the school population, retarded three years or more. The percentage, however, on the basis of total registration varied between 0.7 in one supervisory district and 2.4 in another. Retardation alone, even if fully reported, cannot be an exact basis for the selection of cases requiring special attention from the standpoint of mental hygiene.

(b) The mentally abnormal pupils in a rural school do not constitute the whole number of such children of school age residing in that district. It is likely that the most defective are precisely those who are not in the schools because of the great difficulty of managing them. In the Nassau County Survey[1] in 1916, the bulk of mentally defective children of school age were found outside of the schools. Probably the conditions in Erie County are not markedly different in this respect from those in Nassau County.

The health officer of one township reports as follows: "I know of many mentally deficient children living in this township. They have not been committed to institutions, but are cared for in their own homes. The schools are small here, and the teachers do not object to their attending; otherwise I would have to see that they were expelled from the schools."

The conditions in the rural parts of Erie County suggest the consolidation of small into larger school districts as an essential first step in the organization of mental-hygiene work there.

3. The *parochial schools* contain a large proportion of the children of the county in both urban and rural districts, as is shown in the following statistics:

Registration in Buffalo public schools	54,002
Registration in Buffalo parochial schools	about 28,000
Registration in public schools outside of Buffalo	15,075
Registration in parochial schools outside of Buffalo	about 6,000

1 *Survey of Mental Disorders in Nassau County, New York, July-October, 1916.* By A. J. Rosanoff. New York: The National Committee for Mental Hygiene, 1917. Publication 9.

A beginning has been made toward organizing mental-hygiene work in the parochial-school system, although special classes have not yet been developed either in the urban or in the rural parts of the diocese. Psychometric work has been introduced and found useful in teaching. A physician is employed who has specialized in applied psychology, and in a few instances pupils have been transferred to special classes in the city public schools by special arrangement.

Further development of this work is receiving cautious consideration on the part of the parochial-school authorities.

4. The problems pertaining to atypical children in the *orphan asylums* are similar to those in the schools, except that in all probability the asylums have larger percentages of such children to deal with, and that they not only teach, but also perform services that school children receive in their homes. Moreover, they have charge of many children under school age.

In visits or correspondence with three orphan asylums, a day nursery, a fresh-air mission, and an Indian school, the information invariably given was that the care of mentally abnormal children was not within the scope of these institutions' activities. Just as invariably, however, it was revealed that a number of such children find their way into these institutions and constitute a vexing problem. Owing to the inadequacy of institutional provision by the state for such cases, orphan asylums are often forced to care for them indefinitely.

As it is not their policy to do such work, special classes, systematic mental examinations, and psychiatric work are not attempted by these institutions. One exception was noted in the county—namely, a group of Catholic institutions in Lackawanna, which has a special class and in which a certain amount of psychiatric work is done. (It should be noted that the Thomas Indian School is planning to introduce intelligence tests, and has the coöperation of the state board of charities in its plans.)

Following is a list of institutions for the care of orphaned, dependent, and delinquent children in Erie County:

In Buffalo.
- Buffalo Orphan Asylum.
- St. Vincent's Female Orphanage.
- Fitch Crèche.
- Fresh Air Mission.
- St. Agnes Training School for Girls.
- Asylum of Our Lady of Refuge.
- Charity Foundation of Protestant Episcopal Churches.
- College Crèche.
- Crippled Children's Home.
- Evangelical Lutheran St. John Orphans' Home.
- German Roman Catholic Orphan Asylum.
- Immaculate Heart of Mary Orphan Asylum.
- Jewish Mothers' Club Nursery and Temporary Home.
- Le Couteulx St. Mary's Institution for the Improved Treatment of Deaf Mutes.
- Mt. Carmel Guild Day Nursery.
- Protestant Home for Unprotected Children.
- Rosemary Smith Home.

Outside of Buffalo.
- Our Lady of Victory Infant Asylum, Lackawanna.
- Thomas Indian School, Iroquois.
- Josephine Goodyear Convalescent Home, Williamsville.
- Jewish Fresh Air Camp, Angola.
- Methodist Home for Children, Williamsville.
- St. Joseph's Boys' Orphan Asylum, Lackawanna.

As a special instance of some of the difficult problems occasionally confronting those in charge of orphan asylums, the following may be mentioned:

A boy of unknown parentage, judged to be about four years of age, was found on the doorstep of one of the institutions with a letter pinned to his clothes stating that he had had meningitis and as a result had become mentally defective. At the time the institution was visited, he had been there only a week or two. He bites other children, takes plates and other dishes from the table, digs his fingers into the food, will not use a fork or spoon, is very intractable, and on one occasion tried to throw a glassful of water at the attendant. He walks with an unsteady gait, falls frequently, does not talk, but makes a great deal of noise. The attendant in charge of him thinks that he understands what is said to him, but is disobedient. No one in the institution thinks that he is a suitable case for detention there, but they are experiencing difficulty in disposing of him.

Unusual opportunities for observation and study exist in such of these institutions as care for infants of various ages.

The subject of anomalous behavior in infants has not received the attention and study that it merits. Observations of individual infants here and there in private families, under conditions so varied as to interfere with judgment as to what may be inherent and what of external origin in the tendencies of the child, are not to be compared with similar observations that could be made in institutions where the infants are under more or less uniform or known conditions.

In the ward for infants under one year of age in one asylum visited, the Sister in charge reported that peculiarities of a striking and persistent kind are frequently observed in some infants, who thus are markedly distinguished from others. Some exhibit a habit of rolling the head on the pillow. Others have a habit of rolling the entire body in the crib, which seems to have a sedative effect on the child, who is quiet when permitted to do this and soon goes to sleep, the rolling sometimes continuing after the child falls asleep and then ceasing gradually. Still others have a tendency to cry far more than is usual for infants, such crying being apparently attributable neither to hunger nor to discomfort from any external cause.

5. *Delinquent children* are dealt with partly by the children's court of Buffalo, with which is connected a small detention home; partly by the Children's Aid and Society for the Prevention of Cruelty to Children, which conducts an institution known as the Children's Shelter; and for the rest by the justices of the peace of the various townships in the county for whom is available the coöperation of the chief probation officer of Erie County, whose office is in Buffalo.

The volume of work of these agencies is striking. During the calendar year 1920, which is the last period for which official data are available in a published report, 1,176 cases were disposed of by the children's court, of which 1,060 were cases of boys and 116 girls. Of this number 134 boys and 41 girls were committed to institutions such as the State Agricultural and Industrial School, Industry; St. Agnes' Training School for Girls, Buffalo; New York State Training School for Girls, Hudson; Society for the Protection of Destitute Roman Catholic Children, Lackawanna; Berkshire Industrial School, Canaan, and so forth. Three hundred and thirty-five cases were discharged, 258 reprimanded and discharged,

262 placed on probation, and the remaining 145 disposed of in various ways—placed in the care of the commissioner of charities and corrections, fined, directed to make restitution and reparation, placed in homes, warrant withdrawn, etc. Of all those brought into court 209, or about 18 per cent, received a psychometric examination.

All court cases are investigated by the chief probation officer or one of his three assistants. The court authorities, however, feel that this work falls short of what it should be, both qualitatively and quantitatively. *It should include psychometric work, field investigations by psychiatric social workers capable of taking anamneses, and examinations by psychiatrists. Mental examinations should not be limited, as they are now, to about a fifth of the cases going through the court, but should be applied to all.*

The detention home consists of an old frame residence which has been altered to adapt it to its present purpose. On the ground floor are small offices, a dining room which is also used as the court room, and a small dormitory for girls, with five beds. Upstairs there is a fifteen-bed dormitory for boys. All windows are barred. There is, in addition, a single strong room which is used mainly for isolating venereal cases, but sometimes also for the seclusion of refractory children. There is a rather poorly equipped room for the examining physician, and scarcely any provision for diversion or occupation.

The period of detention is, in most cases, brief. Many stay only overnight, and the average length of stay is five days. The maximum permitted by law is thirty days. Yet some children are kept beyond that period because of lack of room in the institutions to which they have been committed. Occasionally a child is held for two months or more, mainly in cases of girls who are held as material witnesses.

It could hardly be said that the building is suitable for the purpose for which it is used. Furthermore, the dormitories being locked and barred, it would seem that an undue fire hazard is incurred.

The premises are kept in immaculate condition. The personnel are humane and kindly. We have been informed that the children are generally contented there, and many of them, especially the girls, regret leaving and do so at times with tears.

Here, as elsewhere, the work of mental hygiene is hampered by lack of adequate facilities and trained personnel.

The Children's Aid and the Society for the Prevention of Cruelty to Children and Children's Shelter are now merged into one organization, housed in a modern building. About 600 children between the ages of two and twenty-one are admitted a year. The building has a capacity of from 80 to 85 and is well equipped. Children are brought to this Shelter either by agents of the Society for the Prevention of Cruelty to Children or by order of the courts, or are referred by other agencies.

This institution conducts a psychological clinic, which engages the full-time services of a well trained psychologist. Almost all the children receive a psychometric examination, as well as a sociological and physical investigation. The clinic has available also the volunteer services of an excellent psychiatrist, who is in private practice in the city. Between 4 and 5 per cent of all cases have heretofore been referred to him for psychiatric examination.

Further development of this work is contemplated. Plans now being discussed which will probably materialize in the near future will enable the superintendent to provide two wards for psychopathic children, where they may be kept under special observation.

The work of this organization might be helped if more attention were given to the psychiatric training of the social workers employed and if more cases were referred for psychiatric examination. A merging of the work of the children's court with the work of this institution would, if feasible, justify the employment of a psychiatrist on full time and would obviate the need of depending upon free services.

Outside of the city of Buffalo there are no special children's courts, delinquent children being brought, like other cases, before justices of the peace. There are also no places for detaining delinquent children pending investigation and trial, and no facilities or personnel for either physical or mental examinations. Several of the justices were interviewed and all of them have been communicated with. They report that very few children are brought before them. One of them stated: "Since entering upon this office, I have had but one case of delinquency in a child—namely, in a girl about sixteen years

of age who had previously been committed to the House of the Good Shepherd and later was recommitted to the same institution, from which she ran away after breaking down doors, destroying furniture, and so forth. She was recaptured, and her mother took charge of her again. Just where she is now, I am unable to say. There is no doubt in my mind that this unfortunate girl is mentally deficient."

Another, who is both a justice of the peace and a school trustee, stated: "I know of no mental deficiency among the children in this neighborhood at this time. About the only cases that come before me are cases of truancy. Then the parents get it good and hard from me, for we make it as pleasant for the children in school as we can to make them want to come instead of playing hookey."

Still another justice of the peace related the case of a boy who had been brought before him four years previously. This boy had been brought up in bad surroundings. His mother had almost no control over him and he had a stepfather who often whipped him for trifling things, but paid no attention to serious wrongdoings. The boy had vicious tendencies. Once he took a kitten and cut out its eyes to see what it would do and then let it go. He stole knives, pencils, and other articles at school. Once he stole a new copper boiler which his mother had purchased, broke it up, and tried to sell it to the junk dealer. On other occasions he stole a cap and some small change out of a cash register in a store. He was committed to Industry, New York, for a year, but because of bad behavior there was kept a little longer. A couple of years later he took a girl out in a boat on the lake and they were both drowned.

Most of the justices of the peace do not know that the various facilities in Buffalo for the examination of children would be available to them upon application, but those with whom this point was discussed stated that the town would probably object to the expense that would be involved in transportation.

The county probation officer's headquarters are in Buffalo. He is supposed to have charge of children on probation in all parts of the county outside of the city of Buffalo, those in the city being in charge of a special department which the city maintains for that purpose. Owing to the difficulty of trans-

portation and shortage of personnel, the county probation officer has had but little contact with the justices of the peace in the various townships, at least so far as delinquent children are concerned. During the past fiscal year, probably not over fifteen or eighteen juvenile delinquents have been cared for by the county probation officer. The number of cases of children brought into the courts, however, must have been greater.

There is some prospect of an improvement in this situation through an increase of personnel in the department and the availability of an automobile for trips anywhere in the county.

The county probation officer has various ways of having a child examined mentally, such as taking it to one of the outpatient clinics conducted by the Buffalo State Hospital or to the Children's Aid diagnostician. But usually he refers cases to a private physician who is engaged in psychiatric work and has the examination made on a fee basis. Not all children receive a psychiatric examination. This is one of the many instances which show that a better coördination and use of the available facilities for making mental examinations of children would result in more complete and more thorough work.

6. The Erie County *board of child welfare* reports that during the calendar year 1919, 334 families were given aid by their organization and during 1920, 273 families. All children received a physical examination either at one of the health centers in the city or in the city tuberculosis clinic or at the hands of private physicians. During the year 1920, 1,167 children were examined. Only a small number received a mental examination—namely, either those whom the physician making the physical examination especially referred for such an examination or those who were reported as doing very poorly at school.

Owing to the difficulty and expense of transportation, the children in the rural parts of the county are seldom brought to the city for examination and hardly any of them are mentally examined. *If various parts of the county were visited by an itinerant mental clinic, all dependent children in the rural districts could receive a mental examination. The mothers of these children also could receive a mental examination, and thus the law would be more strictly complied with.*

7. The *out-patient mental clinics* conducted by the state hospitals in Erie County consist of three conducted by the Buffalo State Hospital and one conducted by the Gowanda State Hospital, all in Buffalo.

Although both the Buffalo and the Gowanda State Hospitals have announced their readiness to examine either children or adults at any time that they may be brought to the hospital, patients are very seldom thus referred to them. There is a strong and general objection to going to an institution for mental disease or to sending a child there for an examination.

Of the four out-patient clinics, two are as a rule used only for adults, while the remaining two—one conducted at the Jewish Community House every Wednesday morning from 10 to 12, and the other at the Children's Hospital every Thursday afternoon from 2 to 4—are mainly for children. During the year ending June 30, 1921, 148 children under sixteen years of age were examined in this clinic, but scarcely any of them came from the rural parts of the county, owing chiefly to the difficulty and expense of transportation. The great majority of these patients were diagnosed as mentally deficient or mentally retarded, but there were also cases of psychopathic personality, epilepsy, and psychoneurosis, and 23 were designated as normal. Full advantage of these clinics has not always been secured, owing, apparently, to the lack of careful planning in advance as to the type of diagnostic service that might best help the other organizations; but this is merely a matter of adjustment, as the personnel and equipment are of the highest quality.

It is obvious that these clinics are not serving the rural areas of the county, and a mere increase in numbers, even if in new locations, would still leave most of the outlying sections without service.

In order to make psychiatric service available for the schools, justices of the peace, overseers of the poor, health officers, and other organizations and officials throughout the county, it would be necessary to organize an itinerant mental clinic. Such a clinic could visit each of the twenty-five townships in the county outside of Buffalo twice each year, and should be arranged through the county health council in

coöperation with any consultation or supervisory medical work for the schools. These visits, if announced in advance, would enable the rural authorities to have children and others selected for mental examination, so that periodically the psychiatric problems in every community would be placed in the hands of those best able to deal with them efficiently.

As far as the state hospitals are concerned, such an itinerant clinic would not involve the employment of more personnel or the expenditure of a greater amount of time than would be necessitated by the establishment of but one additional fixed out-patient clinic with a single weekly session. The only added expense would be that of automobile transportation once a week.

If the two state hospitals in the county would divide between them this work, so that the Buffalo State Hospital would send out its itinerant clinic to the townships in the northern half, and the Gowanda State Hospital to those in the southern half of the county, then for each of these institutions the establishment of such an itinerant clinic would involve but half the labor and time that would be required for the establishment of one additional clinic in a fixed locality.

If a coöperative plan for itinerant consultations involving more than one medical service should be worked out in coöperation with the proposed county health unit, this would mean decided economy in personnel and transportation.

Outside of the work in their out-patient clinics, the state hospitals have seldom opportunities of rendering psychiatric service in cases of children. This is due to the striking rarity of psychoses in children under sixteen years of age. At the present time there is not one patient under sixteen years of age from Erie County in the Gowanda State Hospital, and but one in the Buffalo State Hospital. During the year ending June 30, 1921, but seven patients from Erie County under sixteen were admitted to the two hospitals, three of whom had manic-depressive psychoses and four dementia praecox.

8. *The department of health* of the city of Buffalo has a special bureau for child hygiene which includes a division for mental hygiene. This division employs a physician on part time who has specialized in psychometric work and who examines cases referred by the schools, the children's court,

orphan asylums, and other city and county agencies. This division works in coöperation with the division for special classes in the department of education.

9. *The department of hospitals and dispensaries* of the city of Buffalo has suggested a far-reaching plan for psychiatric service to be rendered to children in the city schools, such service to be made available for children elsewhere in the county as well by bringing them to the city where the facilities are located.

Considerable progress has been made in the establishment of facilities for such work. In connection with the Buffalo City Hospital, a new psychopathic ward has just been completed and is about to be furnished and opened for the admission of patients. It has a capacity of forty beds, is equipped with hydrotherapeutic, electrotherapeutic, and diagnostic appliances, and has provision for the classification of cases according to sex, age, and mental condition.

The new psychopathic ward is so located in relation to other departments of the hospital that in case of need it would be possible to convert other wards into additional mental wards, thus not only increasing the capacity of the neuropsychiatric service, but also further multiplying facilities for classification.

The visiting physician in charge of the psychopathic ward also holds the chair of psychiatry in the medical school of the University of Buffalo.

10. *The county superintendent of the poor* has his office in Buffalo, and many cases of dependent children are referred to him by overseers of the poor and others throughout the county.

At the time of this study, there were reported to be approximately 2,358 children under the charge of the superintendent of the poor, of whom 1,298 were in orphan asylums and other institutions, and 1,060 were in boarding homes, in free private homes, or with their mothers, to whom maintenance was being paid by the county.

The principal causes of dependency in these children's cases were the illness or death of one or both parents, desertion by father, father in prison, mother feebleminded.

The superintendent of the poor deals with mental disorders

in childhood only in those marked cases in which the necessity arises for commitment to an institution for epileptic persons or for the feebleminded. Although the present incumbent of this office is very conservative in the matter of committing children to such institutions—feeling that it is a step justified only as a last resort and that even a definitely feebleminded child should first be tried in a private home or on a farm before commitment is decided on—yet he finds the state's facilities for the care of children who must be committed to such institutions very inadequate.

At present he states that the county is compelled to maintain fifteen children in the Brunswick Home in Amityville, Long Island, a private institution to which the county pays a certain amount per week for the maintenance of these children.

Not only are the facilities that the state provides for feebleminded, epileptic, and otherwise mentally abnormal children inadequate, but such facilities as are available are in institutions located for the most part hundreds of miles distant from Erie County. Owing to this circumstance, the relatives of children who should be committed are often unwilling to consent to such commitment, as the children would have to be taken so far from their homes that visiting would be rendered difficult or impossible.

From the superintendent of the poor and from other sources we have learned that *there is a great need for an institution for mentally defective persons in the western part of the state.* Owing to the fact that the state makes such inadequate provision, Erie County has developed a plan to build at Alden, where it owns nine hundred acres of land, an institution which would include an almshouse, a penitentiary, and a separate department for mentally defective persons.

11. Erie County, especially Buffalo, is unusually well supplied with neuropsychiatrists. Outside of those who are on the medical staffs of the two state hospitals, there are in private practice at least ten psychiatrists, or neurologists interested in psychiatry, seven of whom have had state-hospital experience. They are available for work on a fee basis; but most, if not all, are also ready to offer their services gratis, so far as they can spare the time, to public institutions. Some

are on the medical staff of the Buffalo City Hospital and others are employed on part time on a small-salary basis by the department of health for psychiatric work.

Agencies Existing Outside the County.

The following institutions in New York State outside of Erie County which are rendering or may render service to children of the county should be especially mentioned, as some of them care particularly for mentally defective persons, and there is as a rule a high percentage of atypical children in institutions of the types represented by the others.

1. *Syracuse State School,* at Syracuse, has 13 children from Erie County. Three others have had applications filed and are on the waiting list.

2. *Rome State School,* at Rome, has 57 children from Erie County. While none are officially on the waiting list, it is reported that many would be if vacancies were known to exist.

3. *Letchworth Village,* at Thiells, has 17 children from Erie County. Two others have had applications filed and are on the waiting list.

4. *Craig Colony,* at Sonyea, for epileptic patients, has 11 children from Erie County; none on the waiting list.

5. *State School for the Blind,* at Batavia, has some children from Erie County; the exact number was not ascertained. The superintendent writes that all newly admitted pupils are given psychometric tests, and that once every year or two a psychologist visits the school and further examines doubtful cases for possible mental deficiency. Children who are found to be of such low mentality as to be unable to profit by the advantages of the school are sent home or transferred to institutions for the feebleminded. Occasionally a case of epilepsy is observed.

6. *The Jewish Orphan Home,* at Rochester, has 19 children from Erie County. Only in a small proportion of cases have psychometric tests been made. The annual report states that occasionally delinquent or feebleminded children are admitted there, although it is contrary to the declared policy of the institution to receive them. When a child is discovered to have a marked mental abnormality, they try to dispose of it either by discharge or by transfer to an institution for the feebleminded.

Recommendations

In order to formulate recommendations for the more purposeful utilization of existing facilities and resources of the county for the work of mental hygiene among children and for the creation of new facilities required to round out the existing organizations, it is necessary, first of all, to determine upon a general plan of mental-hygiene activities as the goal to be attained.

1. *Work in the Schools.* It would seem highly desirable to introduce in the schools the systematic practice of group tests of intelligence. On the basis of these tests and also on the basis of retardation in school work, anomalies of behavior, and evidences of nervous or mental disease, children may be selected for individual examination.

Perhaps the next step would be to provide for individual psychometric tests in all cases thus selected.

The third step would be to investigate the home conditions in each case and to secure full anamneses with the aid of psychiatric social workers. These investigations and anamneses, together with the general medical examinations that school children receive, should form a basis for explaining such phenomena as retardation, truancy, unruliness, and so forth.

The final step would be an examination of the data already collected and of each atypical child individually by a trained psychiatrist, which should lead to a diagnosis and recommendations for the treatment and disposition of the case.

The school system should further develop its facilities, such as special classes, trained personnel, and so forth, for carrying out the recommendations resulting from investigations of children as outlined above.

2. *Work With Children Not in the Schools.* For children who come to attention by reason of nervous or mental disorders developing before or after school age and for those who come to attention by reason of dependency or delinquency, provision should be made for investigation along lines similar to those outlined above for school children.

The plan here suggested would meet to a large extent the social-hygiene needs of children, inasmuch as psychiatric problems are often found underlying social diseases among them. The timely discovery and attack upon such problems

would in many cases constitute a measure of social hygiene—that is to say, prevent venereal disease. For the rest, social hygiene must be considered a part of any well-rounded plan of general health work.

3. *Need of Trained Personnel.* One of the first needs brought to light by this study is that of trained personnel for the various phases of work in mental hygiene. At the present time, owing to the imperfect organization of existing facilities, it is not only true that the energies of the valuable personnel are inadequate for the work that has to be done, but also that these energies are employed in an uneconomical way. It should not be necessary for a psychiatrist of fifteen or twenty years' experience to do psychometric work or take anamneses, inasmuch as many teachers and others can readily be trained to do it.

It is recommended that teachers who are interested in such work be trained to perform group tests. Such work could be safely entrusted to them, as its object would never be the final and definite classification of children, but only a preliminary classification intended as a basis for further investigation. Other teachers, possessing better qualifications of education and experience, should receive more advanced courses of training to fit them for the more responsible work of individual psychometric testing. A third group either of teachers, school nurses, or social workers, should be given courses in psychiatric social work, including practice work in field investigations and obtaining psychiatric anamneses. Finally, a fourth group of teachers should be trained for various phases of work with atypical children in special classes.

In the course of the survey, a canvass was made of educational institutions in which such training might be provided. In the University of Buffalo, Departments both of Medicine and of Arts and Sciences, extension courses and summer courses are already being given in applied psychology, abnormal psychology, and psychiatry. Conferences with heads of departments have led to the conclusion that it would be entirely practicable to outline and provide courses specially devised for training personnel for the various kinds of mental-hygiene work mentioned above.

In the State Normal School in Buffalo there is an excellent

department of psychology in which also far-reaching attempts have been made to develop summer courses in applied psychology. With the increase of the regular normal-school course from two to three years, further development of that work for all student teachers has been planned.

Perhaps the most significant steps in this direction have been taken by the State Normal School in Geneseo in coöperation with the Craig Colony. This school conducts practical courses at the Craig Colony for the purpose of supplying special training to seniors who are interested in work with atypical children. Eight critic teachers have for nearly two years been maintained on full time at the Craig Colony, being paid from the budget from the Geneseo State Normal School a usual salary, minus a deduction of $240 a year in lieu of which they receive room, board, and laundry at the colony.

These teachers have organized classes of from eight to twenty-five pupils selected from among the patients in the colony. The teaching consists in academic work, weaving on looms, lace making, tatting, crocheting, plain sewing, rug making, carpentry, chair caning, toy making out of rags and out of wood, kindergarten training, physical culture, and singing. Groups of about five or six student teachers are assigned to work at the colony for a period of one week for each group. They derive from such an assignment an opportunity to observe methods of instruction; a certain understanding of various mental and physical handicaps which should help them to recognize such handicaps and make intelligent allowance for them upon encountering them in the course of teaching; also a certain amount of training in the work itself that is being taught to the children, such as various stitches, how to use a loom, and so forth.

These courses are optional, but of about 200 senior students no fewer than 120 have signed their names to applications for them. They constitute, of course, only an introduction to the needed training, but the normal-school authorities plan to increase their scope and their variety so as to fit teachers for the various phases of mental-hygiene work among school children, such as those enumerated above.

This special development of the Geneseo State Normal School would by no means eliminate the need for extension

courses in Buffalo University, Buffalo State Normal School, and possibly in Canisius College. For those teachers whose work is in Buffalo it would be advantageous if special courses were offered in the local educational institutions, for only thus would they be enabled to utilize any spare time they may have during afternoons, evenings, and Saturdays for getting such training.

4. *Standards for Psychometric Work.* Perhaps this is the proper place to refer to the uncontrolled and often incompetent psychometric work that is done in many places. It would seem to be the proper function of the American Psychological Association to decide upon standards of requirements for the various kinds of psychometric work that has to be done. Those engaged in this work should be able to show that they have conformed to such standards and should thereupon be officially certified by a proper committee of the association, the certification specifying whether it be for administering group tests, or for individual tests in the capacity of assistant, or for independent work as professional psychologist. Courses offered by the universities, colleges, and normal schools should be planned with a view to meeting such requirements.

5. *Increased Institutional Accommodations Needed.* Very often the recommendations that result from a psychiatric study of a child cannot be carried out on account of lack of necessary facilities. Some of the special needs have already been discussed. The most urgent are a new institution for the feebleminded in the western part of the state of New York, perhaps in Erie County, and the establishment of more special classes for atypical children in the public schools. It should be noted in this connection that, as far as parochial schools are concerned, the Lockwood Law is not mandatory, but optional.

6. *Psychiatric Service for Rural Areas.* The greatest obstacles in the way of organizing special classes are encountered in rural parts of the county. The chief improvements will probably come through the combination of school districts referred to on page 778; but even then rural schools will still be at a disadvantage in comparison with urban

schools, for the reason that one school, even if it be a large one, cannot organize special bureaus like those carried on by the department of education of a large city. While a larger rural school can develop personnel for group testing, individual testing, psychiatric social work, and teaching of special classes, it cannot so readily secure the services of trained psychiatrists whenever needed.

In order to help rural areas, and especially rural schools, meet the need for trained psychiatric service, organization of an *itinerant mental clinic* is recommended. This has already been referred to and its general plan described. Information secured from neuropsychiatrists practicing in and around Buffalo indicates that some, if not all, would be willing to accept positions on the staff of such an itinerant clinic and thus relieve the state hospitals to some extent of the burden of carrying it on. However, such a clinic should be under the control of the state hospitals, just as the fixed clinics are, in order to insure proper supervision, standards, records, and reports. It should, of course, conform to the plans and procedure for the medical examination of school children, especially in so far as they relate to itinerant consultation or clinic work.

7. *Organization for Continuing Work.* The next recommendation deals with the problem of so organizing and controlling mental-hygiene work in the county, especially among children, as to secure for it the highest measure of efficiency with the least expenditure of energy and resources.

There should be some agency for coördinating the mental-hygiene work of the schools of the city and of the rural parts of the county, orphan asylums, children's courts and justices' courts, the Children's Aid Society, the board of child welfare, the two state hospitals, the department of health of the city of Buffalo, the department of hospitals and dispensaries, the office of the county superintendent of the poor, and neuropsychiatrists in private practice.

In order to bring this about, it would perhaps be best to organize an Erie County committee for mental hygiene as a committee of the Erie County health council. To this committee might belong public-spirited citizens and, *ex officio*,

officials who are concerned with the education, management, and control of children, including not only heads of large departments, but also representatives of such groups as the school teachers, nurses, social workers, physicians, psychologists, probation officers, justices of the peace, and overseers of the poor.

This committee should have a carefully selected executive board and should have as one of its objectives the organization, through paid workers, of a complete program of mental-hygiene work in each part of the county, as part of the general public-health program.

The objects of this committee should be carefully formulated, and among its functions should be that of furnishing scholarships to enable teachers, nurses, and others to take special courses of training provided by universities and colleges in extension teaching and summer sessions. It also should be one of its functions to hold from time to time meetings, not only for its own members, but open to the public, at which important subjects in mental hygiene should be discussed by competent authorities in a way to be of educational value to those in attendance.

8. *Research.* In general, the most obvious need for the development of mental hygiene among children—one that did not require a survey to bring it to light—is that of organizing research for increasing our knowledge of the mental disorders of childhood.

Although psychiatry has made great strides in the last twenty-five or thirty years, this part of it has not kept pace with its general progress.

Owing to the fact that any mental disorder occurring in childhood, no matter what its nature, is apt to act as an obstacle to development in intelligence, the tendency has become prevalent to diagnose almost all cases as mental deficiency. This tendency has been strengthened by the undue reliance that it has become customary to place upon a showing made in psychometric tests.

Should it prove possible to organize the work of mental hygiene among children along the lines indicated in the above recommendations, unprecedented opportunities would be created for research in this branch of psychiatry. It need

hardly be emphasized that, with the possible exception of eugenic measures, there is no more important field of psychiatric prophylaxis than that of work among children. It is, therefore, to be hoped that either in Erie County or elsewhere, in the near future, some such organization as is here suggested may be developed and thus the stage set for research and further progress.

THE SOCIAL-SERVICE DEPARTMENT AND ITS RELATION TO AN EXTENSIVE PAROLE SYSTEM.*

HARRY A. STECKEL, M.D.

Senior Assistant Physician, Kings Park State Hospital, Kings Park, New York

FOR more than two years the Kings Park State Hospital has been doing intensive extramural work in the way of parole and after-care. As a result of this work, we have not only gradually increased our number of patients on parole, but we feel that we have during this period collected sufficient data to prove that many patients whom it was formerly thought necessary to detain in a hospital for mental disease may be safely cared for in the community, and even become self-supporting and useful members of society.

The idea of a parole system and of a social-service department is not a new one nor did it originate with us. In fact, as long ago as 1912, Homer Folks, Secretary of the State Charities Aid Association, advocated the establishment of the parole-system and after-care plan that we are now carrying on, with, of course, such amplifications as have been deemed advisable and necessary. We do believe, however, that our work in this line has been more intensive than similar work anywhere else in the state, and that our results will tend to meet many of the objections that have at times been raised against parole and after-care.

Advocates of an extensive parole system often point to its financial benefits, while opponents reply that the added expense of a large social-service department counterbalances to a great degree this financial advantage. In order to show in actual dollars and cents what has been saved the state at this hospital alone during the two years 1918-1919 and 1920-1921, we have collected the following data:

During the fiscal year ending June 30, 1919, we expended for salaries, wages, maintenance, and traveling expenses of

* Read at a special meeting of the Kings Park Medical Society, Kings Park, New York, May 23, 1922.

the personnel of the social-service department and for the transportation of patients, $4,496.38. During this year the daily average number of paitents on parole was 304.

In the year ending June 30, 1921, owing to a large increase in the personnel of the department and the resulting growth of its activities, $14,410.92 was expended for salaries, maintenance, and so forth. However, as a result of the increased activities rendered possible by the augmented personnel, the daily average number of patients on parole during the year was increased to 669, a gain of 365 over the year ending June 30, 1919. The annual cost of maintenance in the hospital being $379.53 per patient, the gross saving amounted to $138,528.45, or a net saving of $128,613.91.

This does not take account of the money earned by patients who were employed during their parole period. We were able to get definite information regarding 280 patients paroled from July 1, 1920, to June 30, 1921. These 280 earned during their parole period $134,344.00.

As to savings, we were able to secure accurate information only regarding patients paroled to general hospitals, and find that 89 patients so paroled have saved $6,282.00.[1]

It seems to us that this is an admirable showing, amply justifying the maintenance of a large social-service department and the continuance of an extensive and intensive parole policy.

Furthermore, every patient on parole makes room for a new patient. If it had been necessary to erect new buildings to house a number of patients equal to the number on parole, there would have been a far heavier expenditure than that actually made.

This is only one of the many advantages of an extensive parole system, but perhaps the one that appeals most strongly to a certain type of "business man", who thinks largely in terms of the dollar.

In addition to this concrete benefit, there are, of course, many others. The paroling of suitable patients helps to relieve the overcrowding that exists in the majority of our institutions. Perhaps even more important, recovery is often hastened when a patient can return to his home and familiar

[1] Corrected to January 1, 1921.

surroundings during the period of convalescence, at the same time remaining under the supervision of the hospital through the agency of an efficient social-service department. Without such careful oversight of paroled patients while they are making environmental readjustments pending complete recovery, it would not be wise or possible to parole large numbers, or to parole them so early after the disappearance of acute psychotic manifestations. This, of course, applies particularly to the recoverable cases.

What about the chronic patients, those whom we do not expect to recover entirely?

We can cite case after case of so-called chronic patients who, in spite of their oddities of conduct or hallucinations, have been able, with assistance, to do well outside the hospital—such patients, for example, as the following:

Case 1. B. E. Ident. No. 82335, female. Admitted April 22, 1915. Age 50. Diagnosis: dementia praecox, paranoid form. Psychosis began six months before admission; heard husband's voice accusing her and telling her that she was going to have trouble. Thought people watched her; thought electricity was being put on her. These trends continued throughout her hospital residence, and she never devoloped insight. She was always quiet and tractable, however, and on July 13, 1920, a position was secured for her with a family in Smithtown Branch. While there, she did excellent work, but early in April 1921 she became acutely disturbed in reaction to tactile hallucinations, and although she was not dangerous in any way, it was found necessary to return her to the hospital. She soon quieted down, however, and was employed about the ward. On June 28, 1921, she was paroled to an employer in Kings Park, where she has been getting on very well ever since, doing housework and taking care of a small child. She has saved approximately $300.00 during these two years. At the present time she has again become rather restless and insists on establishing a home of her own in Brooklyn, but apparently is not reacting to any great extent to hallucinations. The prognosis for recovery in this case is very poor, but we see no reason why she should not be able to be paroled from time to time, and spend the majority of her time outside.

Case 2. H. G. Ident. No. 14990, male. Admitted August 10, 1907. Diagnosis: dementia praecox, paranoid form. Patient came voluntarily to the hospital because he was annoyed by auditory hallucinations, thought people knew his thoughts and ridiculed him. These voices advised him to kill himself and at times threatened to kill him. On admission, he showed nothing other than this, except perhaps a dull, shallow emotional tone. He remained essentially unchanged for more than ten years, still complaining of auditory hallucinations, which annoyed him more or less from time to time, but which did not interfere

to any great extent with his conduct. On October 23, 1920, he was paroled to the custody of St. John's Hospital, Brooklyn, where a position as hospital orderly was found for him. He has been getting along exceedingly well there and his services are not only satisfactory, but he is very popular, and has saved more than $200.00.

Case 3. M. W. Ident. No. 104514, female. Admitted February 14, 1918. Diagnosis: alcoholic psychosis, Korsakoff. She was committed because she went to the homes of neighbors for meals and insulted and inflicted bodily injury upon a neighbor and her children. Acted irrationally. Threatened to kill the neightbor's child. On admission, she showed no restlessness, but exhibited some defect in personality, appearing rather simple and shallow. She had no insight, had vague persecutory ideas, and showed loss of memory for remote events, upon which fact probably the diagnosis was based. She continued to deteriorate, was unusually quiet and seclusive, seldom speaking to other patients. Memory and orientation finally became very much disturbed, but other than this the patient showed nothing unusual and was able to do good work about the wards. On June 30, 1920, she was paroled to the custody of St. Catherine's Hospital, where she has been employed ever since and is doing satisfactory work, although she requires considerable supervision, owing to the fact that her memory is so poor.

To say that a patient belongs in the chronic group means nothing more than that he is suffering from a prolonged mental disease, such as dementia praecox, senile dementia, general paresis, arteriosclerosis, and the like. Complete recovery of such patients is not to be looked for, but partial social recovery is quite possible, everything depending upon a proper adjustment of environmental conditions. Control over the patient's mental state can be exerted within very narrow limits, but control of the conditions of his environment can be developed indefinitely. It is, then, upon this factor of environmental control that we must depend if we are to increase the number of these patients on parole.

True, many of these chronic patients, especially the more deteriorated, earn only very meager wages in addition to their maintenance, but they enjoy the advantage of living outside an institution for mental disease, have as a rule more comfortable quarters—at least less crowded—and show a distinct elevation of morale such as comes only with a sense of independence, never enjoyed by those within an institution.

We have found that it is very difficult to arrange for the parole to relatives of chronic patients, particularly those whose hospital residence has been prolonged, chiefly because

the family is apt to have so modified their domestic life that it becomes impractical to take the patient back into the home. They have possibly been repeatedly told that the patient would never recover, would always require hospital care, and they have adjusted their lives accordingly. We now believe that no case should be given so hopeless a prognosis, but that the relatives should rather be encouraged in the hope that, although the patient may never completely recover, there is every possibility that he or she will improve sufficiently to permit of extramural care. By thus holding the interest of the patient's relatives, we are later on better able to arrange for a trial on parole within the home; and with a liberal parole policy, we believe that the average length of hospital residence may be appreciably reduced.

A glance at the following table may be enlightening:

Table 1. Length of Hospital Residence of Patients Paroled During the Years Ending June 30, 1920 and 1921

Hospital Residence	1920	1921
Less than 1 month	64	65
1 to 2 months	87	107
2 to 3 months	72	85
3 to 4 months	41	62
4 to 5 months	38	56
5 to 6 months	26	51
6 to 7 months	46	21
7 to 8 months	38	28
8 to 9 months	30	22
9 to 10 months	26	19
10 to 11 months	20	18
11 to 12 months	24	20
1 to 2 years	146	158
2 to 3 years	88	81
3 to 4 years	70	78
4 to 5 years	41	60
5 to 6 years	30	45
6 to 7 years	15	28
7 to 8 years	18	15
8 to 9 years	13	22
9 to 10 years	10	21
10 to 15 years	26	55
15 to 20 years	13	25
20 to 25 years	3	23
25 to 30 years	4	2
More than 30 years	3	5
Total paroled patients	992	1,172

It will be noticed that during the year July 1, 1920, to June 30, 1921, the tendency has been to parole more patients within the first six months after admission than during the previous year. Also, the number of so-called chronic patients paroled shows a marked increase over the previous year, this being especially noticeable in those patients whose hospital residence has been more than four years. This, we think, shows the effect of intensive effort to parole larger numbers of patients and indicates an increasingly liberal policy toward parole possibilities.

To return to the consideration of the benefits of intensive parole work, do we notice any beneficial effect upon the patients who remain in the hospital?

Dr. Rosanoff[1], in a recent paper on the parole system and its relation to occupational therapy, said: "Perhaps the most significant result has been the development of workers out of previously idle patients and the striking general improvement produced thereby in their mental condition. Some improved sufficiently to be in their turn paroled for extramural employment." We believe, therefore, that a liberal parole policy is of actual value as a therapeutic agent and, as Dr. Rosanoff pointed out, "acts as a powerful stimulus, inducing many to work who under ordinary conditions stubbornly remain idle".

It would be natural to expect that if we depleted the hospital of all its trained workers, the work of the hospital would suffer. This, however, has not occurred to any noticeable degree. Perhaps a little extra work has fallen to the attendants in that they were required to train previously idle patients and consequently maintain a closer supervision of the work, but the condition of the wards and grounds has, we think, actually improved, in spite of the fact that the majority of our best workers among the patients have been paroled.

An important question to be considered in connection with an extension of the parole system concerns the types of patients that may be safely paroled. To answer this one must ask another—namely, what is meant by "safely"? I

1 *The Parole System and Its Relation to Occupational Therapy*, by A. J. Rosanoff and T. S. Cusack. *The American Journal of Insanity*, October 1920, Vol. 77, pp. 149-63.

think I may say that, briefly outlined, our policy at this hospital has been that any patient who is neither suicidal nor homicidal, whose behavior would not in any way prove annoying to his neighbors or whose actions would not tend to bring him into undue prominence, should be considered a parole possibility. Needless to say, no patient who is noisy or destructive to property should be paroled, as no amount of environmental adjustment could effectually prevent such patients from annoying those about them.

Aside from the suicidal and homicidal patients, whose parole, of course, is not permissible, and the noisy or destructive patient, there are two other types of patient whose tendencies, although not strictly speaking dangerous, are apt to get them into difficulty or to bring them unduly to public attention.

The first is the type commonly known as chronic elopers. Our experience has been that although a certain proportion of patients who escape from the hospital do so because they wish to reach their homes, a great majority of them are simply chronic wanderers and would fail to remain for any length of time in any one environment, no matter how suitable or how comfortable it might be for them. It is exceedingly difficult to keep in touch with these patients and they are always being picked up by the authorities because of their oddities of conduct or their inability to support themselves. The following is a typical case:

Case 4. H. A. Ident. No. 97729, male. Age 39. Admitted March 31, 1921, by transfer from Brooklyn State Hospital, where he was admitted April 17, 1917. Psychosis was characterized by auditory hallucinations, apprehensiveness, and delusions of persecution. Improved shortly after admission and soon became quite efficient in caring for the sick. August 13, 1918, he was paroled and employed as a ward attendant. This continued for only five days, when he began reacting to auditory hallucinations and was again returned to the ward on August 28. April 1, 1919, he was again paroled and employed. July 7, 1919, he left the hospital without notice and was returned July 12, complaining of auditory hallucinations. March 8, 1920, he was again paroled and employed, but on March 25 he left without notice, going to a rooming house. He was returned March 27, saying that everybody was against him. September 4, 1920, he escaped from the grounds, going to Baltimore, and was returned from there September 29. March 31, 1921, he was admitted by transfer to Kings Park State Hospital. He was an excellent ward worker, showed no trends of any kind after a month or

two, and on September 6, 1921, was paroled to the custody of St. Mary's Hospital. On September 19, 1921, he was returned from parole, having left St. Mary's Hospital seeking another position. Being unsuccessful in this, he voluntarily gave himself up to the police, who sent him to Brooklyn State Hospital. Since this time the patient has escaped from the hospital on one other occasion, but was picked up the same day several stations distant from the hospital and returned. This patient apparently is unable to remain for any length of time in any one place, and is a wandering type for whom parole is contraindicated.

The other type of patient that is apt to attract too great public attention, and that therefore may be said to be in the class of patients not to be paroled with safety, are those who, owing to some persecutory trend, are in the habit of writing letters to prominent people, such as police commissioners, mayors of cities, governors of states, and even the President of the United States. We believe that, although this tendency does not constitute an actual danger, it is annoying to those who receive the letters and is certainly a contraindication to extramural care, for no matter how close supervision may be, the patient invariably gets letters into the mails. This not infrequently happens even while the patient is in the hospital, so that we feel safe in saying that it would be utterly impossible to prevent it outside the hospital.

With the exception of the above mentioned types, we believe that any patient may be safely paroled, given the proper supervision and the proper environmental adjustment.

Table 2 shows the psychoses of patients paroled during the two-year period 1919-1921.

Table 2. Diagnosis of Patients Paroled During the Years Ending June 30, 1920 and 1921

Psychosis	1920	1921
Dementia praecox:		
paranoid form	333	385
simple form	69	74
hebephrenic form	54	71
catatonic form	30	29
Manic-depressive psychosis:		
manic type	96	100
depressed type	82	97
mixed type	52	51
Constitutional psychopathic personality	42	67
Mental deficiency	38	55

Psychosis	1920	1921
Psychoneurosis	29	18
Alcoholic psychosis	47	45
General paresis	24	22
Epileptic psychosis	18	36
Involution melancholia	20	22
Paranoid condition	21	40
Other psychoses	37	60
Total	992	1,172

So far as we know, no special significance can be attached to these figures, and it is quite possible that there might even be some dispute as to the accuracy of the diagnoses made. What we wish particularly to show is that practically all psychoses appear on the table and that the matter of parole should not depend upon the diagnosis made for classification purposes. In discussing the types of patients possible for parole, we have deliberately avoided referring to diagnosis because we consider it irrelevant, the relationship of the symptoms to the environment being the essential factor.

We have, without mishap, paroled patients who are still hallucinated. Hallucinations may be harmless so long as they are not of a persecutory variety. Even where of a persecutory nature, if they are of long standing and if the patient's emotional reactions have become blunted by deterioration, the hallucinations seldom interfere with his ability to get along well outside.

One case of this nature will bear citing:

Case 5. H. L. S. Ident. No. 16628, male. Admitted April 5, 1905. Age 35. Single. Commitment stated that onset was gradual. Patient seemed depressed; spoke freely about his delusions and hallucinations; showed no insight into his condition. Patient said *that for the past few weeks men had been following him about in the streets, and when he went home at night, they would gain access to the house to spy upon him;* he could overhear conversations in which they plotted against him, threatening to shoot him or to get rid of him in other ways. While he was in jail, they attempted to poison him. A diagnosis of dementia praecox, paranoid form, was made. The patient continued throughout his hospital residence to react to auditory hallucinations, upon which were based delusions of persecution. He was, however, quiet and tractable, working about the grounds, and for several months prior to his parole, he enjoyed a ground parole. October 23, 1920, a position was found for him in the Cumberland Street Hospital, where he did portor work for several months. This gave him an opportunity to get in touch with his former friends and members of the Printers' Union

and he is now employed as a night linotype operator by one of the well known New York City morning papers, earning from $65.00 to $70.00 per week. His general attitude remains unchanged, he being seclusive, at times almost odd in his behavior; but he is well able to get along outside the hospital.

Persecutory trends often are directed against friends or relatives. It has been our experience that patients with such trends are well able to get along in an environment removed from relatives or friends. The patient seldom makes any attempt to locate such imagined persecutors, especially if there has been a long hospital residence with some slight dulling of the emotional reactions.

Marked deterioration, oddities of conduct, hallucinations, even mild persecutory trends are, therefore, not contraindications to parole. We believe that the safety of parole depends not so much upon the symptoms of the individual patient as upon the environment into which he is paroled and in which he is to be cared for, each case having some special features that must be especially dealt with in adjusting the environment.

It is the function and the purpose of the social-service department to make these adjustments—this being accomplished at the pre-parole visits—to see that special provisions with reference to the after-care of the patients are carried out, and to be on the alert for new symptoms if they should arise, thus forestalling the difficulties that might come up should the patient's condition change while on parole.

It is our opinion, therefore, that the more efficient the social-service department, the greater the number of patients who may be safely paroled and the more successfully will such patients be held on parole.

Thus far we have referred particularly to patients paroled to the custody of relatives, as they constitute the majority of our parole population. What can we do for patients whose relatives are not able, because of financial or other reasons, to assume their care?

Here, again, we call upon the social-service department for assistance. Occasionally we have been able, through friends of the patient, to secure suitable quarters and some sort of employment for him, but our greatest success has been accom-

plished in placing both men and women in general hospitals, where they are employed as porters, ward orderlies, elevator operators, waitresses, chamber maids, kitchen helpers, and so forth, at wages ranging from $10.00 to as much as $72.00 per month and maintenance.

Some of our markedly deteriorated chronic patients have for more than two years successfully held positions of this kind. At this date there are ninety-one patients on parole employed at the various general hospitals in Brooklyn and New York City, while fourteen discharged patients still hold the positions we originally found for them. Many of these are successful, not because they have recovered entirely from their psychoses—indeed, quite a few are still quite actively psychotic—but chiefly because a general hospital, being institutional in nature, approaches closely the environment from which they have just come. Furthermore, those in charge of these hospitals, being fully aware of the patient's condition, pay little if any attention to his eccentricities and have learned to humor them much as we do.

Our employment worker, who visits these various hospitals frequently, is called upon from time to time to adjust difficulties between employer and employed, but as a rule they get along exceedingly well, and we are told that our patient help is much preferred to the so called "floating employee" otherwise available for positions of this kind.

There are also innumerable demands for patients to perform domestic service in private families, but as these positions require the better class of more responsible patients, we are never quite able to meet the demand.

We have successfully placed a number of male patients in jobs on farms, but the majority of our patients are city bred and it is often difficult to induce them to accept employment of this nature.

Many patients originally placed by us in positions have, after becoming rehabilitated to extramural conditions, been able to go back to work at their former occupations and are now earning normal wages, while not a few whose relatives feared to give them a trial at home have, after proving their worth, been welcomed back to the family fold.

The unemployment that has prevailed for a year or more has militated against us; had the industrial condition of the country remained as it was in late 1919 and early 1920, we feel confident that we would have even better results to show.

Table 3 shows the number of months passed on parole by patients during the two years ending June 30, 1922:

Table 3. Length of Time on Parole of Patients Paroled During the Years Ending June 30, 1920 and 1921

Time on Parole	1920	1921
Less than one month	146	212
1 to 2 months	57	82
2 to 3 months	40	46
3 to 4 months	30	34
4 to 5 months	33	31
5 to 6 months	21	33
6 to 7 months	211	27
7 to 8 months	10	15
8 to 9 months	26	23
9 to 10 months	24	20
10 to 11 months	24	17
11 to 12 months	28	10
12 months	342	622
Total paroled patients	992	1,172

The large number of patients under the six-to-seven-months period in the year from July 1, 1919, to June 30, 1920, is explained by the fact that at that time many of our cases were discharged at the end of six months. As many remain out six months or more, and as not a few require return to the hospital between the six- and twelve-months period, we have recently been paroling practically all patients for one year. The above table indicates, we think, that the majority of our patients need our supervision for at least a year and many of them for an even longer period. This, we believe, justifies the adoption of the one-year-parole practice.

It is needless to say that repeated trials on parole should be made, as not infrequently our original judgment of the patient with relation to his environment may have been at fault. The following table shows the results of repeated trials:

Table 4. Repeated Trials on Parole From July 1, 1919, to June 30, 1921

Number of Trial	Discharged	On Parole	Returned
Second	91	12	113
Third	10	34	29
Fourth	1	12	7
Fifth	..	1	2
Sixth	..	1	..

Many of the patients above had trials previous to July 1, 1919.

These figures demonstrate that we are justified in giving patients a second, a third, or even a fourth, fifth, or sixth trial—under different conditions, of course—on the assumption that they will eventually fit properly into the environment provided for them.

A study of the parole activities at this hospital during the past two years shows us that from July 1, 1919, to June 30, 1920, 487 men and 505 women—a total of 992—were placed on parole. Of this total 91 were patients who escaped. Many of these, of course, remained on parole only a day or two, while others returned home and were regularly paroled to the custody of their relatives. Of the 992 patients, 883 were paroled to relatives or friends, 40 to employers, and 69 to general hospitals for employment.

During the year July 1, 1920, to June 30, 1921, 585 men and 587 women—a total of 1,172—were paroled, a gain of 180 over the number for the preceding year. Of these, 101 were escaped patients.

It was during this year that we began reparoling certain cases for an additional year, so that the total 1,172 includes 126 reparoled for a second year. This means, therefore, that we made an actual gain of only 54 over the number of new paroles during the preceding year. These patients, excluding reparoles, were paroled as follows: to relatives 786, to employers 99, to hospitals 161. Reparoled to relatives 93, to hospitals 30, to employers 3.

During the ten months of the current year—namely, from July 1, 1921, to April 30, 1922—there were 478 men and 374 women paroled, excluding reparoles, of which there have been 170. If the average rate is maintained during May and

June, we will have paroled approximately 1,200 patients during the current year.

Activities that result in such numbers of patients on parole of course require a great amount of work both inside and outside the hospital. The officers and employees of all the departments of the hospital are to be commended for the energy they have expended and the coöperation they have shown in carrying on this work within the hospital. At the same time, we must admit that without the untiring efforts of our social-service department in the field, such satisfactory results could never have been attained. The writer takes no credit to himself for the success of the work accomplished, except perhaps so far as the general organization and direction of the department are concerned, and therefore avails himself of this opportunity to compliment the field workers for their splendid work during the past two years. A brief description of the social-service department may be of interest:

As a definitely organized unit, with a corps of specially trained field workers and a physician in charge of its activities, the social-service department of the Kings Park Hospital has come into existence only within the last two years. In this short space of time, its function has become fairly well defined.

It occupies the position of an auxiliary to the medical department, under whose general control and direction its activities are conducted.

It is a recognized fact that to understand mental disorders one must study the patient, not only in cross section as seen on the hospital wards, but also in his social setting, thus obtaining some knowledge of the personal and human aspects of his condition. One must know him as he appears in his ordinary daily life, and study his emotions and his reactions in his difficulties as well as his pleasures.

It is this social knowledge concerning the patient that the social-service department has attempted to place in the physician's hands, thus broadening the scope of his resources in the way of treatment and adjustment and adding, so to speak, the human element to his scientific and technical view of his patients.

Through the information the field workers bring the physician, they often are able to make a valuable contribution to diagnosis. They may learn much as to the etiological factors upon which the prognosis of the case often depends, for frequently these upsetting factors, especially if they are of the environmental type, may be modified so as to permit of an early parole, and such modifications may prove a valuable background for rehabilitation.

The results of our parole work make increasingly evident the fact that the more intensive and intelligent the preparole preparation of the environment for the patient, the more successful the adjustment is apt to be. Many of our patients exhibit difficulties of adaptation that are, for the most part, associated with their respective settings of environment, habits, or temperamental friction, all of which may be corrected.

After the patient leaves the hospital, the social-service department becomes the sole means of contact of the hospital with the patient and here renders its most valuable assistance. In their regular visits to the homes of our patients, our field workers are able to watch carefully the reaction of the patient toward his surroundings, to scrutinize the attitude of the family toward him, and to give advice as to the best method of procedure in the treatment of any difficulties that may arise.

It is the function, therefore, of the field workers of this department to meet problems that involve family and social relationships, and by dealing with temperamental difficulties, peculiarities, disappointed ambitions, and the like, from a psychiatric standpoint, to render them harmless.

We have felt for a long time, perhaps unjustly, that members of the medical staffs of hospitals frequently pay too little heed to the recommendations regarding extramural adjustments made by the field workers, and to their decisions regarding the advisability of parole or the return of patients from parole. We should bear in mind that the intelligent treatment of mental disorders involves sociologic as well as medical problems, and that only through friendly coöperation and mutual understanding between the physician and the social worker can the best results be obtained.

In addition to the general field work outlined above, the

department operates two out-patient clinics, is not infrequently called upon to examine prisoners in the county jails of both Suffolk and Nassau counties, and more recently has taken up anti-syphilitic work, not only for patients on parole, but for the families of all syphilitic patients admitted to the hospital.

Table 5, which shows our activities during 1920 and during 1921, reveals how rapidly the work has grown:

Table 5. Extramural Activities, Kings Park State Hospital, for the Years Ending June 30, 1920 and 1921

	1920	1921
Visitors to clinics (all classes)	1,453	2,418
Visits to paroled patients	426	2,541
Other visits	164	745
Situations obtained	68	259
Letters written	431	1,860

In conclusion, we want to emphasize our opinion that the matter of granting parole must be a purely medico-social question, and that although there is an economic feature to be considered, the number of paroles should not be altered for the sake of economic advantages alone. Considering the first factor of parole, the patient's mental condition, we realize that desire alone cannot increase the number of recoveries from mental disease. The mental condition of the patient is a fact and cannot be altered because the taxpayers desire it.

The mental condition, however, is not the only element to be considered. Parole is also determined to a large extent by the possibility of securing a suitable environment outside the hospital. So far as recovered cases are concerned, the fact of recovery is the decisive point. But many paroles are possible without complete recovery, depending entirely upon the possibility of placing the patient under favorable conditions. It is, therefore, necessary to adapt the environment of the patient to his mental condition, so that our problem at once becomes social and educational as well as medical. Success in paroling increasingly large numbers of patients depends largely upon a proper adjustment of the patient's environment, the supervision given the patient at the hands of the

hospital, and the early recognition of the return of mental symptoms by the family, the employer, or the visiting social worker. In the case of chronic patients, we think that much could be done by carrying occupational therapy into the home. Where patients are not sufficiently recovered to compete in the industries, they might, having shown skill in basket weaving and the like, continue such work in the home. This, however, would necessitate an extramural occupational therapist, and this degree of organization we have not as yet attained.

We believe that a constant observation should be kept for patients with parole possibilities, and that wherever a patient is found whose symptoms do not contraindicate it, every effort should be made to arrange the extramural environment to receive him and to keep that environment adjusted to his needs through the constant supervision of a social worker. This, we contend, should be a state-wide policy.

Possibly, as has been recommended by the State Charities Aid Association, the organization of a state social-service department, whose function it would be to promote such a policy throughout the state-hospital system, would cause considerable saving to the state, and by relieving overcrowding as it now exists, would permit of more intensive work among those patients still in need of hospital care.

Given such a policy, we are of the opinion, judging from our own experience, that on a conservative estimate any state hospital could during each year parole between 15 and 20 per cent of its total population and could maintain a daily average of at least 10 or 12 per cent (exclusive of reparoles) on parole. To do this properly there should be not less than one field worker for each 100 patients on parole.

Reparole privileges should be increasingly liberal.

We have found little objection on the part of patients to reparoling for a second year; in fact we have not infrequently been requested by relatives as well as patients to continue the parole even to a third year. This, of course, we have not been doing, but we see no reason why there should be any set limit to the time a patient can be carried on parole, provided it is agreeable to all concerned.

ALCOHOLIC PSYCHOSES BEFORE AND AFTER PROHIBITION

HORATIO M. POLLOCK, PH.D.
Statistician and Editor, New York State Hospital Commission

THE only nation-wide information concerning alcoholic psychoses among admissions to institutions for mental disease available prior to 1919 is that contained in the Federal Census report on the insane in hospitals in 1910. On the schedules that were filled out for admissions during that year, the question was asked whether the patient was suffering from alcoholic psychosis. The term "alcoholic psychosis" was defined in the instructions for filling out the schedules as follows: "By 'alcoholic psychosis' is meant one of the mental diseases which, by their characteristic symptoms, are known to be the direct result of alcoholic intemperance. Cases of mental disease in which alcoholic intemperance is only one of the etiological factors and cases merely associated with alcoholic intemperance should not be reported under alcoholic psychosis."

Of the 60,769 patients with mental disease admitted to institutions in 1910, 6,122, or 10.1 per cent, were reported to be cases of alcoholic psychosis. The annual rate of admission of alcoholic cases was 6.7 per 100,000 of the general population. Considerable variation in rates was found in the several census divisions.

Table 1. Alcoholic Cases among Admissions to Institutions for Mental Disease in the Several Census Divisions, 1910

Division of United States	Per Cent of Total Admitted	Rate per 100,000 of Population
New England	12.9	13.7
Middle Atlantic	11.0	8.4
East North Central	10.0	7.2
West North Central	7.8	5.0
South Atlantic	8.0	4.4
East South Central	7.3	3.2
West South Central	8.1	2.7
Mountain	13.9	8.5
Pacific	12.7	10.5
Total	10.1	6.7

It was found by this census that patients with alcoholic psychoses constituted 12.4 per cent of admissions from urban districts and 6.4 per cent from rural districts. The rate per 100,000 of population in urban communities was 10.7 and in rural, 2.6.

Of the 34,116 males admitted in 1910 to hospitals for mental disease, 5,220, or 15.3 per cent, had alcoholic psychoses. Of the 26,653 females admitted, 902, or 3.4 per cent, were diagnosed as alcoholic. The rates per 100,000 population of same sex were 11.0 and 2.0 respectively.

The figures above cited for the Middle Atlantic Division correspond closely with those compiled by the statistical bureau of the New York State Hospital Commission for the year 1910.

In gathering data concerning admissions, the latter bureau separates first admissions from readmissions, as it is believed that the rate of first admissions constitutes a better measure of the incidence of mental disease. The yearly record of first admissions with alcoholic psychoses to the thirteen civil state hospitals of New York State since 1909 is as follows:

Table 2. First Admissions with Alcoholic Psychoses, Civil State Hospitals of New York, 1909-1921

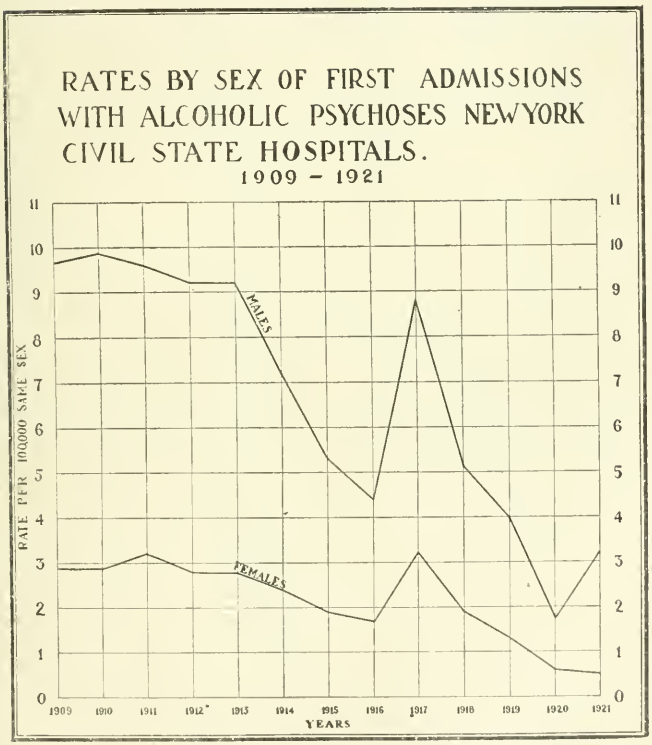
	Number			Per Cent of All First Admissions		
Year	Males	Females	Total	Males	Females	Total
1909	433	128	561	15.6	5.8	10.8
1910	452	131	583	15.3	5.0	10.5
1911	444	147	591	14.7	5.5	10.4
1912	434	131	565	14.4	4.8	9.8
1913	438	134	572	13.7	4.7	9.4
1914	348	116	464	10.4	3.6	7.4
1915	255	90	345	7.8	3.1	5.6
1916*	215	82	297	8.4	3.5	6.1
1917	437	157	594	12.1	4.8	8.6
1918	257	97	354	7.3	3.0	5.2
1919	204	65	269	5.8	2.0	4.0
1920	90	32	122	2.7	1.0	1.9
1921	167	26	193	4.6	0.8	2.8

* Nine months.

It will be noted from Table 2 that a marked decline in the number of alcoholic first admissions began in 1914 and be-

came more pronounced in 1915. In 1916 a slight change in trend occurred, and in 1917 a decided reaction took place, the number of alcoholic cases in that year exceeding that of 1913.

Chart I



In 1918, 1919, and 1920, the number of these cases fell off rapidly and reached its lowest point in 1920. In 1921 the male alcoholic cases increased, although there was a further reduction in female cases. The chart above shows graphically the rates for both sexes since 1909, based upon the general population. These rates are found in the following table:

Table 3. Rates of Alcoholic First Admissions to the New York Civil State Hospitals per 100,000 of the General Population of the State, 1909-1921

Year	Rate per 100,000 of General Population of Same Sex		
	Males	Females	Total
1909	9.7	2.9	6.3
1910	9.9	2.9	6.4
1911	9.6	3.2	6.4
1912	9.2	2.8	6.0
1913	9.2	2.8	6.0
1914	7.2	2.4	4.8
1915	5.3	1.9	3.6
1916*	4.4	1.7	4.0
1917	8.8	3.2	6.0
1918	5.1	1.9	3.5
1919	4.0	1.3	2.6
1920	1.7	0.6	1.2
1921	3.2	0.5	1.8

* Nine months

Correlation of Alcoholic Admissions and Per Capita Consumption of Liquors

That the rate of first admissions with alcoholic psychoses is closely correlated with the per capita consumption of liquors is seen from a comparison of the following index numbers computed from official reports for the years 1909 to 1920:

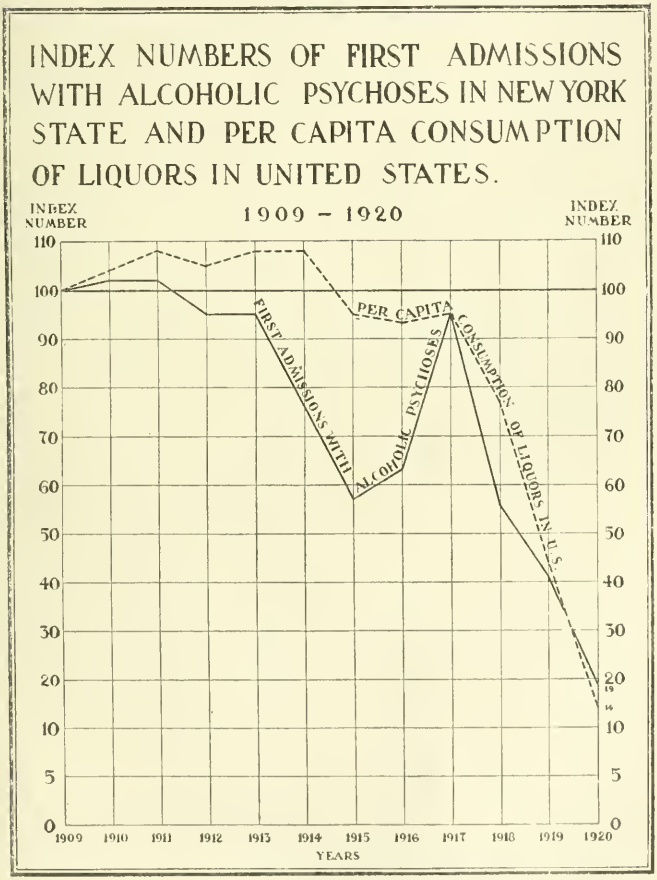
Table 4. Index Numbers of Rates of Alcoholic Psychoses and Per Capita Consumption of Liquors, 1909 to 1920

Year	Index numbers of rates of alcoholic first admissions to New York state hospitals	Index numbers of per capita consumption of liquors in United States
1909	100	100
1910	102	104
1911	102	108
1912	95	105
1913	95	108
1914	76	108
1915	57	95
1916	63	93
1917	95	95
1918	56	77
1919	41	44
1920	19	14

The coefficient of correlation between the two series of numbers is $0.875 \pm .045$. It is probable than an even closer

correlation would have been found had data relative to the per capita consumption of liquors in the state of New York been available. (See Chart II.)

Chart II



Decline of Alcoholic Psychoses in Massachusetts

The figures given above showing the decline in alcoholic psychoses in recent years in New York State are paralleled by data compiled from the official records of the state of

Massachusetts by Cora Frances Stoddard,[1] from whose study the following table is taken:

Table 5. First Admissions with Alcoholic Psychoses to Massachusetts State Hospitals for Mental Disease and McLean Hospital, 1912-1921

	Alcoholic First Admissions	
Year	Number	Per cent of total first admissions
1912	301	11.3
1913	367	11.8
1914	311	10.4
1915	299	9.5
1916	289	9.1
1917	511	12.3
1918	304	8.1
1919	296	7.8
1920	102	3.6
1921	151	4.9

The number of cases among all first admissions in which there is a record of intemperate use of alcohol shows a corresponding decline during the same period in both New York and Massachusetts. The data for New York State are given in Table 6:

Table 6. Intemperate Use of Alcohol Among First Admissions, New York Civil State Hospitals, 1909-1921

	Intemperate Users of Alcohol					
	Number			Per cent of total first admissions		
Year	Males	Females	Total	Males	Females	Total
1909	1,229	369	1,598	44.2	15.1	28.7
1910	1,684*	488*	2,172*	56.9	28.7	38.1
1911	1,082	302	1,384	35.9	11.2	24.3
1912	1,097	273	1,370	36.5	10.0	23.8
1913	1,103	318	1,421	34.6	11.1	23.5
1914	1,027	258	1,285	30.8	8.8	20.5
1915	939	225	1,164	28.8	7.5	18.7
1916†	725	182	907	28.2	7.8	18.5
1917	1,152	300	1,452	32.0	9.2	21.1
1918	851	253	1,104	24.1	7.7	16.2
1919	804	161	965	22.8	4.9	14.2
1920	684	119	803	20.3	3.7	12.2
1921	691	131	822	18.9	4.0	11.8

* Includes moderate drinkers.

† Nine months.

1 *Wet and Dry Years in a Decade of Massachusetts Public Records*, by Cora Frances Stoddard. *The Scientific Temperance Journal*, June, 1922, Vol. 31, pp. 1–54.

The gradual decline in the excessive use of alcohol indicated by the above table constitutes good evidence that a marked change in the habits of the general population with respect to the use of alcohol had been taking place for several years prior to the enactment of the Volstead Law. The change began before the World War, but was halted by the reaction of 1917. Later it was accelerated by war-time restrictions.

Alcoholic Admissions in 1921

The following tables, compiled by Miss Edith M. Furbush, Statistician of The National Committee for Mental Hygiene, from original standardized reports of state hospitals, give the latest available data concerning the prevalence of alcoholic psychoses in various parts of the country:

Table 7. Alcoholic Psychoses among First Admissions to State Hospitals in Fourteen States, 1921

State	Total First Admissions	Alcoholic First Admissions	
		Number	Per cent of all first admissions
California	2,459	110	4.5
Colorado	457	4	0.9
Maine	399	17	4.3
Massachusetts	2,538	130	5.1
New Hampshire	260	12	4.6
New Jersey	1,301	28	2.2
New York	7,104	210	3.0
Ohio	2,838	61	2.1
Pennsylvania	1,508	39	2.6
Rhode Island	329	19	5.8
South Carolina	740	9	1.2
South Dakota	193	1	0.5
Vermont	140	3	2.1
Virginia	1,315	24	1.8
Total	21,581	667	3.1

These representative data show that only 3.1 per cent of first admissions to state hospitals in 1921 were cases of alcoholic psychoses. Compared with figures previously given from the Federal Census of 1910 and the reports of the New York State Hospital Commission, a marked general decline in alcoholic insanity is shown. This is further evidenced by

the data of all admissions shown in Table 8, which is on nearly the same basis as the Federal Census figures:

Table 8. Alcoholic Admissions to State Hospitals in Fourteen States Compared with All Admissions and General Population, 1921

State	Total Admissions	All Alcoholic Admissions		Rate per 100,000 of General Population
		Number	Per cent of all admissions	
California	3,098	133	4.3	3.8
Colorado	480	5	1.0	0.5
Maine	490	20	4.1	2.6
Massachusetts ..	3,349	174	5.2	4.5
New Hampshire.	301	14	4.7	3.2
New Jersey.....	1,557	38	2.4	1.2
New York.....	9,235	255	2.8	2.4
Ohio	3,539	77	2.2	1.3
Pennsylvania ...	1,728	47	2.7	0.5
Rhode Island....	413	24	5.8	3.9
South Carolina..	938	10	1.1	0.6
South Dakota...	256	1	0.4	0.2
Vermont	197	3	1.5	0.9
Virginia	1,597	30	1.9	1.3
Total	27,178	831	3.1	1.9

It will be noted that the rate of admissions with alcoholic psychoses in these states was only 1.9 per 100,000 population, as compared to 6.7 for the whole country in 1910. During the year 1920, the first year under prohibition, alcoholic admissions to state hospitals were less than in 1921.

Table 9. Prevalence of Alcoholic Psychoses in Twenty States, 1919-1921

State	Number of Alcoholic First Admissions			Rate of Alcoholic First Admissions per 100,000 of Population		
	1921	1920	1919	1921	1920	1919
Arizona	*	3	..	*	0.9	..
Arkansas	*	8	5	*	0.5	0.3
California	110	*	*	3.1	*	*
Colorado	4	1	2	0.4	0.1	0.2
Connecticut	*	*	31	*	*	2.3
Georgia	*	9	9	*	0.3	0.3
Iowa	*	20	26	*	0.8	1.1
Maine	17	6	18	2.2	0.8	2.4
Massachusetts	130	91	295	3.3	2.4	7.8

State	Number of Alcoholic First Admissions			Rate of Alcoholic First Admissions per 100,000 of Population		
	1921	1920	1919	1921	1920	1919
Nebraska	*	*	6	*	*	0.5
New Hampshire	12	12	16	2.7	2.7	3.6
New Jersey	28	27	*	0.9	0.9	*
New York	210	143	285	2.0	1.4	2.8
Ohio	61	64	*	1.0	1.1	*
Pennsylvania	39	*	*	0.4	*	*
Rhode Island	19	14	19	3.1	2.3	3.2
South Carolina	9	5	6	0.5	0.3	0.4
South Dakota	1	2	..	0.2	0.3	..
Vermont	3	2	2	0.9	0.6	0.6
Virginia	24	21	30	1.0	0.9	1.3

* Data not available.

Table 9 gives comparative data for several states for 1919, 1920, and 1921. Although the table is incomplete, it shows considerable reduction in alcoholic admissions in several states from 1919 to 1920 and an increase from 1920 to 1921. The reaction in 1921 may be due to lax enforcement of liquor laws or perhaps in part to the economic depression.

Table 10. Sex of First Admissions with Alcoholic Psychoses in Twenty States, 1919-1921

State	1921			1920			1919		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Arizona	*	*	*	3	..	3	..	..	..
Arkansas	*	*	*	8	..	8	5	..	5
California	102	8	110	*	*	*	*	*	*
Colorado	3	1	4	..	1	1	2	..	2
Connecticut	*	*	*	*	*	*	27	4	31
Georgia	*	*	*	8	1	9	9	..	9
Iowa	*	*	*	20	..	20	25	1	26
Maine	16	1	17	6	..	6	17	1	18
Massachusetts	102	28	130	78	13	91	241	54	295
Nebraska	*	*	*	*	*	*	6	..	6
New Hampshire	9	3	12	12	..	12	15	1	16
New Jersey	25	3	28	25	2	27	*	*	*
New York	184	26	210	110	33	143	216	69	285
Ohio	57	4	61	60	4	64	*	*	*
Pennsylvania	34	5	39	*	*	*	*	*	*
Rhode Island	17	2	19	11	3	14	17	2	19
South Carolina	9	..	9	5	..	5	6	..	6
South Dakota	1	..	1	2	..	2	..	..	..
Vermont	2	1	3	1	1	2	2	..	2
Virginia	22	2	24	18	3	21	27	3	30

* Data not available.

Table 10 shows the sex distribution of the alcoholic first admissions in the several states. Relatively the decline in female alcoholic first admissions in 1920 and 1921 was more than in male cases. These results correspond with those found by Miss Stoddard[1] in her study of the effects of prohibition among women. She states: "The women have apparently gained more than the men under prohibition, perhaps because they are less exposed to the bootleggers' blandishments and are less likely to seek out the tribe. At all events, the average number of women in all penal institutions of Massachusetts on September 30, 1920 and 1921, the two dry years, was the lowest of the decade, 60 per cent smaller than the wet years' average, while the total prison population on this date had dropped 52 per cent.

"A decrease of practically one-half in the number of commitments to the State Reformatory for Women in the two prohibition years carries a stage farther the story, not only of the passing of the alcoholic women from penal institutions, but also of other women offenders."

Environment of Alcoholic Cases

During the entire period for which we have adequate data, alcoholic psychoses have been much more prevalent in urban than in rural districts. As previously mentioned, in 1910 the rates of all alcoholic admissions in the United States per 100,000 of general population of the same environment were 10.7 and 2.6 respectively. The admissions from urban districts in that year constituted 77.8 per cent of all the alcoholic admissions. Since 1910, the proportion of alcoholic cases from urban districts has increased. In a study[2] of first admissions to the New York civil state hospitals from July 1, 1915, to June 30, 1920, it was found that 90.9 per cent of the alcoholic first admissions were from urban districts. The average annual rate per 100,000 of general population was 3.7 in urban districts and 1.6 in rural districts. Representative data compiled by Miss Furbush from state-hospital re-

1 See note page 820.

2 *Mental Disease in Cities, Villages, and Rural Districts of New York, 1915–1920*, by Horatio M. Pollock and William J. Nolan. *State Hospital Quarterly*, November 1921, Vol. 7, pp. 38–65.

ports of several states in 1919, 1920, and 1921, show the following percentages:

Table 11. Environment of First Admissions with Alcoholic Psychoses, 1919-1921

(Representative data compiled from state-hospital reports of several states)

	Urban		Rural	
Year	Number	Per cent	Number	Per cent
1919.....	333	85.6	56	14.4
1920.....	400	83.9	77	16.1
1921.....	622	84.4	115	15.6

As the number and location of the state hospitals reporting were not identical in the three years, the above data are not strictly comparable, but indicate clearly the preponderance of cases of alcoholic psychoses in urban districts.

Conclusions

1. Marked reduction in the prevalence of alcoholic psychoses throughout the United States has taken place since 1910. This is due partly to restrictions on the liquor traffic and partly to changes in the habits of the people.
2. The lowest rate of first admissions with alcoholic psychoses occurred in 1920; a reaction occurred in 1921.
3. The rate of alcoholic first admissions is closely correlated with the per capita consumption of liquors.
4. The reduction in the rate of alcoholic psychoses has been relatively greater among women than among men.
5. Admissions with alcoholic psychoses come principally from urban districts.

THE SANATORIUM

SUSANNE HOWE

I. 4.45 a.m.—The Adirondack Special.

The vague, shrill howling of a lonely train
Far off among the soon-forgetful hills.
For night's revolting draft of fresh, red pain
The stale grey recompense of dawn again.

II. 12.30—The Dinner Gong.

Gaunt, trousered ghosts rise from the porch and go,
Obedient to a cheerful little bell,
To eat and drink, with lean jaws moving slow.
"How long, O Lord?" the only grace they know.

III. 5.00—Rest Hour.

The band brays on the main street where the corps
Of rookies drills before the gaping town.
The very trees stand higher to see more.
How is it that men know of just *one* war?

—*Contemporary Verse.*

THE PIONEER

ARTHUR GUITERMAN

Long years ago I blazed a trail
Through lovely woods unknown till then,
And marked with cairns of splintered shale
A mountain way for other men;

For other men who came and came:
They trod the path more plain to see;
They gave my trail another's name,
And no one speaks or knows of me.

Another's name my trail may bear,
But still I keep, in waste and wood,
My joy because the trail is there,
My peace because the trail is good.

—*The Outlook.*

ABSTRACTS

Problems Confronting the Section of Nervous and Mental Diseases. By Peter Bassoe, M.D. *The Journal of the American Medical Association*, 78:1857-58, June 17, 1922.

In this paper, the chairman's address to the Section of Neurology and Psychiatry at the annual meeting of the American Medical Association last May, Dr. Bassoe reviews briefly the causes that have led to the great increase in public interest in neuropsychiatric problems, and emphasizes the fact that it is the duty of the medical profession to meet the new demand of jurists, educators, and the public in general for information and guidance, since "experience has shown again and again the importance of the medical point of view in connection with these problems". He warns the medical profession that it has no time to lose before facing these issues: "One has merely to observe the tables of contents of popular magazines and the subjects of lectures before clubs and public and private gatherings of all kinds to appreciate the extent of the invasion of the field of psychopathology by all kinds of lay psychoanalysts and psychologists, some of them well trained and well meaning, other dangerously contaminated by occultism, obscurantism, commercialism, or by all of these. Let us apply prophylaxis before radical treatment becomes necessary: We must persist in hammering on the necessity of teaching more psychology and psychiatry to medical students and of making these subjects compulsory for graduation."

Only by such training of physicians will it be possible to uproot one of the greatest difficulties in the way of neuropsychiatric prophylaxis—namely, the popular impression that there is a sharp line of demarcation between nervous disorders and mental disorders, that the latter are mysterious and terrible maladies appearing suddenly out of nowhere. Neurology and psychiatry, Dr. Bassoe believes, should be welded together in theory as well as in practice, since "a neurologist who is ignorant of morbid mental processes and a psychiatrist unfamiliar with organic nervous diseases are equally undesirable".

If the medical profession is to furnish advisors to the public in regard to problems that vitally affect human conduct, it is essential that it have the confidence of the public. For this reason, the profession in general and neurologists and psychiatrists in particular should work to eradicate an evil that has repeatedly brought the profession

into discredit with the public, and that is the present method of giving medical testimony in courts, particularly in cases involving questions of insanity and mental responsibility. Of this Dr. Bassoe says:

"The usual practice of each side selecting experts who appear in court with a partisan label has led to ills so well recognized that I will dwell on only one of them: the resulting public distrust of our opinions. We share this problem with all medical and other professional men, such as chemists and engineers, but we suffer relatively more damage to our reputations, as cases involving questions of mental responsibility are prone to attract a great deal of popular interest and to be exploited by the sensational press. Even the most discriminating lay people are tempted to question not only the exactness of the knowledge, but the common sense and sometimes perhaps also the sincerity of physicians giving testimony in such cases. If we do not always appear sensible and trustworthy when under oath to tell the whole truth, can we expect the public to trust us as advisors in their serious and intimate personal problems?"

As a first step in combating this evil, Dr. Bassoe recommends the adoption of a suggestion recently made by Dr. Herman Adler "that the American Medical Association create a council on medical jurisprudence 'whose main task shall be to work out and establish standards in this subject which can serve as guides not only for physicians, but for the legal profession as well'."

Study of the Case Preliminary to Treatment. By William Healy, M.D. *Journal of Criminal Law and Criminology,* 13:74-81, May, 1922.

Dr. Healy feels that the present tendency in legal circles and among workers with delinquents to give up theorizing about such generalities as the question of heredity versus environment, the fact and age of responsibility, and so on, marks the first stage in the evolution of a new science, analogous to that phase of development in the physical sciences when they turned from attempts at classification and deduction from incomplete data to studying and experimenting with the materials and phenomena under discussion. The need for such a new science—a science of human behavior—is clearly indicated by the fact that theories with regard to the problems of delinquency—and there have been countless theories, theological, philosophical, sociological, biological, even psychological—all break down when it comes to handling effectually the definite, concrete problem presented by the individual delinquent, different in a thousand ways from every other delinquent.

Involving as it does matters of the utmost importance to the well-

being of all society and dealing with the most delicate organisms in the world—human beings—work in the field of juvenile delinquency demands the deepest scientific understanding, yet little attempt has been made to put it upon a scientific basis. In the first place, no particular professional training has been required of its personnel. In the second, no really adequate records have been kept by courts, probation officers, and corrective institutions—records from which it would be possible to draw conclusions with regard to the two plain, practical issues: (1) how the court can cope with various causes of delinquency and (2) with what reasonable expectation it can prescribe particular sorts of treatment when dealing with individuals who vary so widely in needs and possibilities that what will serve in one case will unquestionably fail in another.

There is a tendency to place too much reliance upon the establishment of a system—the probation system, for example—which may amount to nothing more than a routine procedure without any provision for meeting constructively the needs of individual cases. In this connection, Dr. Healy notes the recent attempt to take over a little psychological science, "with a jump at the idea that there can be handed out overnight a percentage statement which shall represent the so-called intelligence of delinquents, or at the idea that some few words of classification will tell a valuable story about the individual".

Again, the impression still prevails that it is the offense that must be treated rather than the individual offending—that certain types of offense call for reformatory treatment or removal from home, while others do not. As a matter of fact, a slight offense may be associated with significant behavior tendencies—meanness, cowardly lying, bad attitude toward parents, and the like—that can be brought to light only by a study of the case. On the other hand, an offense that is serious from the legal standpoint is not necessarily indicative of a trend toward criminality.

The worker with juvenile delinquents should know his material as the engineer knows his—how it will behave under various stresses and how it can be strengthened. Difficult as such knowledge is to attain in view of the complexity of the material, it is no more than fair that one who undertakes to handle such complex matters should "be in some position to answer the question of what this individual can do or is likely to do in education, in work, in conduct, or what is apt to take place if he is sent to this or that institution, or if he stays at home, or if he has special chances given him, and these points should be known early in the procedure with him for the sake of economic effort".

As steps in putting this work upon a more scientific footing, Dr. Healy makes the following recommendations: "(1) Better training of the personnel, beginning with the judges. (2) The placing of this whole work upon a professional basis through such training and through the education of the public. What has already taken place during ten or fifteen years shows the great possibilities in this direction, including the matter of adequate financial support. (3) The forming of an association of juvenile-court judges, meeting as other professional men, with closely knit interests, gathering together, not for the purpose of self-advertisement or presentation of superficial statements, but with the idea of gaining much from the experiences of others and from the interchange of scientifically worked up data concerning types of cases and other special problems. (4) The focussing upon the fact that the real results of effort in our field are to be measured by the nonrecurrence of delinquency; in other words, therapy is the aim, and cure is the measure of success."

Two Twilight Zones in Health Administration. By E. R. Kelley, M.D. *American Journal of Public Health*, 12:563-67, July, 1922.

This paper is the presidential address delivered at the Thirty-seventh Annual Meeting of the Conference of State and Provincial Health Authorities, at Washington, May 15, 1922. Dr. Kelley feels that the tremendous expansion of public-health-administration work during the last twenty years, and the tendency to carry this work still further into every department of human affairs, make it necessary for public-health officials to consider carefully what should be the actual extent of their legal and moral jurisdiction in the development of personal and group hygiene. Certain functions, such as the control of communicable diseases, fall beyond doubt within the exclusive province of the official health department, but it is a question whether certain others, even though distinctly governmental, cannot be better administered by some other department of the government than the health department. It is a question, too, whether some of the more recently recognized health problems, which are now being handled by voluntary health societies, may not be for some time to come more adequately dealt with by such agencies than by a governmental department. Two of these border-line or twilight-zone public-health fields that are of great importance are those of school hygiene and mental hygiene.

School hygiene, in Dr. Kelley's opinion, has suffered greatly from a general confusion with regard to the proper division of duties between departments of health and departments of education. Func-

tions that in some places are performed by the health departments in others are carried on by the departments of education, and vice versa; and only too often the subject falls between the two stools and neither department has anything to do with it. The remedy for this condition is to make a clear distinction between the functions that have to do with the health supervision of school children and those that have to do with their health training or physical education, and to assign the one to the health departments and the other to the departments of education.

Mental hygiene as a public-health problem is in an even more nebulous state. Let alone the fact that it is only just beginning to be recognized as a part of the public-health movement, no attempt has been made to determine to what governmental department it properly belongs. Obviously it represents a far wider field than that at present covered by the state departments of mental disease, yet it is possible that such departments might be reorganized not only to include mental-hygiene work, but to make it the corner stone of all their activities. Again, since mental-hygiene work must be first and foremost work with children, it may be that it can best be developed and administered by the departments of education. And from another point of view, mental hygiene is a health problem, and there are good reasons for assigning it to the departments of health.

"The most significant characteristic of the entire subject of mental hygiene to-day, however, is that, generally speaking, neither departments of health, mental diseases, nor education officially recognize its existence.[1]

"Most commendable work is being done and great interest is being aroused in the subject in the two countries here represented, but entirely by voluntary societies and committees of mental hygiene. Individual members of governmental, psychiatric, educational, and health organizations are taking a keen interest in participating in the activities of these voluntary societies, but public opinion has not yet advanced to the point where the obvious next step, the active official participation of one or all of these departments in the work of mental hygiene, has been demanded.

"Because it seems quite clear that such a demand will be made in

[1] In this connection it is interesting to note that after the preparation of this paper two bills were introduced in the Massachusetts Legislature, one providing for changing the name of the Massachusetts Department of Mental Diseases to the Massachusetts Department of Mental Health, and the other creating a division of mental hygiene in the same department. The latter was approved and became a law, June 8, 1922; the former was referred to the next general court. These measures indicate a growing recognition of the need for official organized effort along the lines of mental hygiene.

the near future", Dr. Kelley concludes, "the time seems to have arrived when this subject should be given a prominent and permanent place in the deliberations of this conference. I earnestly recommend that we study this subject, solicit the assistance of representatives of voluntary societies for mental hygiene as advisory-committee members, solicit also the coöperation of educational and psychiatric officials, and thereby see if this conference cannot take the initiative in so shaping the development of this great and important phase of hygiene that the friction and misunderstandings that in the past have sadly marred and delayed the harmonious development of a continent-wide policy of school hygiene may be avoided."

Mental Hygiene in Its Relation to Present-day Nursing. By L. Vernon Briggs, M.D. *The Modern Hospital,* 19:236-40, September, 1922.

This is an urgent appeal to the nursing profession to devote more attention to the subject of psychiatric nursing. Dr. Briggs emphasizes the point that mental nursing is no longer limited to the care of the so-called insane and the feebleminded. As psychiatry begins to play a more and more important part in the fields of social and preventive medicine, there is an increasing demand for nurses with psychiatric training, not only in hospitals for mental diseases and general hospitals, but in industry, the schools, and public-health work in general. Moreover, the need for such training is not confined to those who intend to specialize in mental and nervous diseases—every nurse needs it; mental symptoms are often present in diseases that the general nurse is called upon to handle—indeed, every illness has its mental aspect—and a nurse is frequently hampered in her dealings with patients by lack of knowledge of the psychiatric problems involved.

The difficulty in interesting nurses in work with mental patients Dr. Briggs believes to be due to two causes—first, the old superstitions prejudice against the mentally ill that has lingered on from the dark ages, but is dying away as the realization grows that mental diseases are diseases like any other; and, second, the neglect of psychiatry in medical schools. Physicians who have not themselves been trained to recognize mental diseases have naturally not expected their nurses to understand mental nursing. This condition will remedy itself as psychiatry takes its proper place in medical education; the young general practitioner who has had psychiatric training will demand that his nurse shall know at least how to observe and report early mental symptoms and to care for incipient cases of mental disease. As physicians who desire to practice in Massachusetts are now

required to pass an examination in psychiatry, so, in Dr. Briggs' opinion, nurses should be obliged to qualify in psychiatric nursing before being allowed to register. He advocates also an exchange affiliation of the general hospitals with the state hospitals.

Organization of Social Work in a State Hospital. By Mortimer W. Raynor, M.D. *The State Hospital Quarterly,* 7:319-25, May, 1922.

The author is director of clinical psychiatry at Manhattan State Hospital, and his discussion is based upon the organization of social work at that hospital. He assumes that social workers are assigned in the ratio of one to each one hundred patients on parole.

He classifies the various phases of the work as follows:

1. At time of admission of patients
   (a) Investigations to locate interested friends and relatives
   (b) Amelioration of home and family conditions
   (c) Gathering of social-history data
2. Follow-up work during hospital residence
   (a) Amelioration of home and family conditions
   (b) Development of plans for leaving hospital
3. Preparole
   (a) Investigations and establishing entrée with family
   (b) Report to physician
   (c) Adjusting of home and family conditions for the patient's return home
   (d) Securing of home or boarding house and a job
4. After-care
   (a) Supervision through clinics
   (b) Supervision through visits to home and plan of employment
   (c) Advice and assistance in maintaining adjustments, and promoting a salutory mental atmosphere in the home
5. Mental hygiene in community
   (a) Contact with other agencies doing social work, the schools, and correctional institutions and agencies, etc.

The discussion brings out clearly the fact that the work depends upon the close coöperation of physician and social worker. The latter interviews newly admitted patients and their relatives and friends, makes home investigations, and so forth, and the social data thus obtained are compiled and supplied to the physician for the patient's

folder, to assist him in understanding the patient and his needs. Plans for parole are formulated under the guidance of the physician; and when parole is actually under consideration, the social worker is equipped by the physician for her preparole investigation with a comprehensive outline of the case, including the patient's present mental and physical condition, the factors involved in his maladjustment, and the like. The results of the investigation—comprising full statements as to the type of environment to which the patient will return, his family and their attitude toward him and plans for him, and the social worker's own recommendations on the case—are reported back to the physician, who compiles from them a brief statement of the home situation, formulates the social problems involved, and adds his recommendations as to parole, with specific directions to the social worker on such points as amount and kind of supervision, employment, recreation, medical care, and the like. The case is then brought up for discussion at staff meetings, where final recommendations are made. When a patient is paroled, the social worker is supplied with full data on the case, including the staff-meeting discussions and recommendations. Parole patients reporting at clinics are interviewed both by physician and social worker, the latter making such home visits as are necessary, and throughout the parole period frequent conferences are held between physician and social worker, that every new situation may be met promptly and intelligently. So far as possible, especially after parole, one worker should follow a case through to its conclusion.

The experience of Manhattan State Hospital, Dr. Raynor concludes, "has shown the absolute necessity of supplying the social workers with full data concerning the patient's previous history, psychosis, and condition at time of parole and detailed and specific directions for meeting the problems of after-care. This in turn has necessitated the careful formulation of the social problems involved by the physician in charge of the patients."

WHAT PATIENTS MAY SAFELY BE PAROLED. By Russell E. Blaisdell, M.D. *The State Hospital Quarterly,* 7:311-18, May, 1922.

Writing from his experience with the parole system as first assistant physician at Kings Park State Hospital, Dr. Blaisdell divides the patient population of a hospital into three main groups: (1) those who are fit for parole under practically all conditions; (2) those whom it is unsafe to parole under any circumstances; (3) those whose cases call for careful study. Group 1 includes convalescent patients and patients who have not shown dangerous or untoward tendencies;

group 2, patients with suicidal or homicidal tendencies and patients who are restless, excited, depressed, violent, or destructive, or who require more skilled care than can be provided in a private home; in group 3, probably the largest of all, the advisability of parole depends not only upon the personality of the patient himself and the type of his psychosis, but upon the results of a thorough investigation of the environment to which he will go, the care and supervision that will be given him by relatives and friends or employers, and the efficiency of the hospital's social-service department.

Generally speaking, the parole list of a hospital will increase in proportion to the liberality of the management's point of view and the effort that is made to discover patients suitable for parole and to provide adequate supervision for them. "Both viewpoint and effort will vary greatly in different institutions as well as in the same hospital from time to time. This is well shown by comparing the average percentage of cases on parole from the thirteen civil hospitals of the state [New York] during any fiscal year. In the year ending September 30, 1914, the percentage varied from 1.84 in the lowest to 6.42 in the highest, while during the year ending June 30, 1920, the variation was still more marked, being from 2.30 to 11.50. At Kings Park the average percentage during the years 1913 and 1914 was 4.1 while during the last fiscal year it was increased to 13.4."

Every hospital probably contains large numbers of patients who have passed the acute phase of their illness and are no longer dangerous, but who for economic reasons, "and because of what has aptly been termed hospital inertia", have been kept in confinement longer than was necessary. Frequent surveys will disclose such patients in almost every ward of the hospital, including even those for disturbed or infirm patients. They may still show symptoms—hallucinations, bizarre notions, incoherency, odd behavior, and the like—but none of these is an absolute bar to parole. Dr. Blaisdell is convinced that there are comparatively few patients in civil hospitals who cannot be safely paroled under favorable conditions. He warns, however, that great care should be used in the selection of patients for parole, since there is always an element of hazard under any parole system; doubtful cases should be referred to the superintendent, upon whom the ultimate responsibility rests. Chances of unhappy results from an extension of the parole system will be reduced to a minimum by an efficient social-service department headed by a full-time physician, who should have entire supervision of patients through the parole period, conducting the clinics at which the patients report, having charge of the histories and social-service records, handling all correspondence, and directing the social workers' visits to patients. The

importance of reporting regularly at an out-patient clinic for observation and advice should be impressed upon the patients and their relatives, and patients who do not or cannot report should be visited by a social worker at their homes or places of employment.

The Library in the Mental Hospital. By Edith Kathleen Jones. *The Modern Hospital*, 18:535-36, June, 1922.

The author of this article is the former librarian of McLean Hospital, Waverley, Massachusetts. The mental hospital, she states, needs a pretty, cheerful library even more than the general hospital, since there are few bed patients in the former and the other patients are likely to be restless and eager to get away from the monotony of the wards.

The mental-hospital library can use a much better class of book than the library of the general hospital, whose patients, staying only for short periods and with minds wearied by illness or operations, usually want only the lightest of fiction. Mental patients, on the other hand, stay for long periods and are often in good physical condition and mentally alert. They are in many cases as much interested in the outside world as any one and frequently carry on courses of study or even conduct original research; consequently they want atlases, dictionaries, and reference books of all sorts. The great desire, however, is for fiction.

The selection of the books is all-important. The impression produced by a book is much deeper upon a mind in an abnormal condition than upon a normal mind, with its many interests and preoccupations. The mental patient may be depressed or excited or thrown into an agony of fear by books that would have little effect upon the ordinary reader. In choosing books for the mental-hospital library, therefore, the quality of "wholesomeness" is the one to which all others should be subordinated. To illustrate, the author gives the following list of "don'ts":

"Don't provide for mental patients stories having insane, degenerate, epileptic, or otherwise mentally affected characters; stories in which suicide is accomplished or attempted, especially if the means of suicide are carefully described (as in Wells' *History of Mr. Polly*); morbid or depressing novels, tales which deal with unhappy childhood, marital infelicities, physical deformities which warp a man's nature (like *Sir Richard Calmady*) or which end unhappily; sex-problem or erotic novels, though they be numbered among the best sellers; 'psychic', psychological, or self-analytical stories, however well written; ghost stories, because they never can have satisfactory endings and they haunt the patient; stories which have gruesome or

bloody details or which depict horror (Stevenson's *The Merry Men* and Conan Doyle's *The Hound of the Baskervilles* for example). In addition to this taboo fiction, discard most if not all books on psychology, religious discussion, law, medicine, and mental hygiene; never give a patient any books on these subjects without the approval of the physician in charge."

The books that should find place on the shelves of the mental-hospital library are clean, entertaining stories, fine, thoughtful novels, detective tales that dwell upon the skillful unraveling of the mystery rather than upon the details of the crime, nature books, books of travel and adventure, biographies, essays, poetry, and the like.

The selection of books for the individual patient is also important. If there is a librarian—"and without one the library is about as useless as a laboratory without a director"—she should study case records and talk over cases with doctors and head nurses, so that she may choose for each patient the books that are best adapted to his particular needs.

In addition to this work with individuals, there should be a carefully selected assortment of books in the sitting room of each ward, changed each week, and destructive patients should be given plenty of magazines and books not worth rebinding. Mention is also made of the value of reading aloud in wards of listless or depressed patients.

Medical Services Money Cannot Buy. By H. E. Kleinschmidt, M.D. *Medical Review of Reviews,* 28:94-6, February, 1922.

The physician, especially the venereal-disease physician, is often confronted with situations that require the utmost tact and consideration, as well as judgment. A number of illustrative cases are given. Dr. Kleinschmidt points out the following guiding principles:

The psychological reaction of the patient should be anticipated and respected. Whereas bluntness may stir one individual to action, it may crush another of more sensitive fiber.

The physician must bear in mind the effects his answers may have on the family and the social relationships of the patient. The right answer involves an understanding of the mental make-up of the patient's relatives as well as of the patient himself.

Finally, the physician must always consider the possible effect of his answer on public health. Social obligations are to be considered as well as professional ethics. There is no such thing as a privileged communication when the health of others is endangered. The practice of medicine can be made a commercial enterprise or a profession, according to the motive of the individual physician.

BOOK REVIEWS

THE KINGDOM OF EVILS; PSYCHIATRIC SOCIAL WORK PRESENTED IN ONE HUNDRED CASE HISTORIES TOGETHER WITH A CLASSIFICATION OF SOCIAL DIVISIONS OF EVIL. By E. E. Southard, M.D., and Mary C. Jarrett, with an introduction by Richard C. Cabot, M.D.; a note on Legal Entanglement as a Division of Evil, by Roscoe Pound; and an appendix on Legislation in Relation to Mental Disease, by Frankwood E. Williams, M.D. New York: The Macmillan Company, 1922. 708 p.

There was a time, in the memory of psychiatrists who are not yet old, when psychiatry had but little contact with the rest of the world. This was when the psychiatrist was only an alienist, concerning himself mainly with "insanity" and discussing his subject matter entirely from the criteria of the insane hospital. This was as if zoölogists were concerned only with adult elephants and refused to talk about fetal or baby elephants and disregarded entirely the lesser living creatures.

It is not to be denied that there have been gallant figures in psychiatry who pushed boldly into other realms than their own. Though Morel, Esquirol, and the French school of psychiatrists may have been mistaken in their every conclusion, yet their generalization that neuropathy and psychopathy extend into crime, eccentricity, genius, and social disorder of all kinds was a fruitful one and brought into social thought, into society, the idea that conduct must be examined from the standpoint of the psychiatrist before it can be classed, condemned, or punished. This idea Lombroso elaborated, and Nordau extended, and extravagant and ill-founded as their conclusions, or rather premises, were, yet as a result of their teaching and preaching, psychiatry entered the fellowship of those disciples and sciences that seek to adapt man to the world and the world to man.

But generalizations and the impetus that comes from books solve but few individual problems, and it is individual problems in which the human being is mainly interested. Psychiatry remained in the insane hospitals; psychiatrists developed the medical side of their problems, evolved dementia praecox, manic-depressive insanity, separated out general paresis from the organic diseases, studied the pathological and serological relations of their science—basic efforts, indispensable, hugely important, but still without a great and notice-

able result upon society. There had to be evolved groups of workers who would be mainly interested in the social effects of mental disease, who would wonder why Mary Jones remained a prostitute and why Richard Roe remained out of work, who would labor to readjust this or that person to society, who would seek the advice and information necessary wherever it was to be found. In other words, the evolution of the social worker was necessary before the psychiatrist could penetrate into society and bring to bear upon its social problems his knowledge and experience. The approach of the psychiatrist to society and of society to the psychiatrist came through the social worker, and the locus of such coöperation between psychiatrist and social worker was necessarily some such nodal point of the Kingdom of Evils as the Psychopathic Hospital.

Before the psychiatrist could be so available, the traditional insane hospital, sequestered in its rural fastness, had to evolve into a metropolitan institution, freely accessible to every worker, interested in every problem of human maladjustment and misery, in touch with courts, doctors, relief agencies, into which there might flow a stream of cases representing all degrees and shades of mental diseases.

Such a hospital is the Boston Psychopathic Hospital, over which presided the lamented Southard, and whose social service was directed by Mary C. Jarrett. These two, surveying their experiences in this remarkable hospital, have written a book, *The Kingdom of Evils,* here reviewed, a book that cements psychiatry and social service in a union that nevermore should grow lax or be broken.

The Kingdom of Evils deals with a hundred unfortunates, into whose lives the five great evils of disease, ignorance, bad habits and vices, legal entanglements, and poverty, have entered in one form or another so as to bring them to the Psychopathic Hospital. In a simple narrative manner the authors set forth the history of each case, show how the patient came to the hospital, what was done, and what the result was. Though success is claimed where success was gained, failure is acknowledged with an unusual frankness, and throughout there are a modesty and a balance wholly admirable.

The technique of case description is essentially a layman's account, though written by Southard, the psychiatrist, pathologist, and philosopher. The analysis of each case is along obvious lines, no effort being made for subtlety, and I fear that Freudians will be quite disgusted with a work that considers sex only where it is obvious, and discusses complexes—almost not at all. We are introduced, not to people described with fine and minute detail, but to men and women drawn with bold strokes, and in relation to their main and obvious difficulties.

WOMAN, 43. LIVING AS MAN 12 YEARS

1916	*1916–18*
Man's dress	Woman's dress
Inebriate	Drinking spells
Irregular work	Steady job
Bisexual deliuquency	Books and a pipe

Early history
Married. Deserted
Abandoned child
Put on disguise

Southard has taken these bold outlines of the case as furnished by Miss Jarrett and tells, in good Anglo-Saxon language, of Julia Brown, of her stock, of how she married a hard-drinking man who left her shortly after the birth of a baby boy. Putting the baby, whom she was never to see again, in his aunt's care, she went back to the mill and worked three years. In the late teens or early twenties, Julia Brown put on men's clothes and from that day forward never wore women's clothes again until she came under care.

"We have presented the case as one of non-medical and non-educational nature, although it would be easy to say that she is so far a victim of psychopathic personality that medicine has an important part in the plot, and it will also be easy to show that her life has been such that a part of her plight was due to ignorance. Nevertheless, we are not prepared to say that she is definitely a psychopath in the sense of sundry cases of overdeveloped instincts or of a definite psychopathia sexualis. She may belong, as hinted, in that wide and vague circle of eccentrics and cranks that lie in the limbo outside the circle of the psychopathias. Educationally, the woman is well informed and writes a good letter; there is no obvious gap in education to make up. On the other hand, there was, of course, a large moral problem and the question of readjustment of the entire attitude of this woman to her life. We have purposely laid little stress upon the sex delinquencies, heterosexual and homosexual, which are suspected or implicit in some parts of Julia Brown's history. With a case of congenital psychopathia sexualis, we question whether our social treatment would have been so relatively successful and so quickly productive of results as the above account indicates. In short, the readjustment problem was more a moral than a psychiatric one, despite the fact that the psychiatric point of view was no doubt of the utmost service in picking the situation to pieces and parting out the moral from the distinctly psychopathic elements of Julia Brown. The element of delinquency needs no further analysis than what the history reveals, and the economic problem, though never desperate,

required a good deal of help and indeed from time to time actual money grants.

Hours spent by	Medical record, 27 pages Social record, 48 pages
Physician, 5	Social work:
Psychologist, 1	Visits, 49 Interviews at hospital, 14 Telephone calls, 53
Social worker, 95½	Letters, 21''

And so we are introduced to Herman Simonson, ''intelligent clothes presser, disabled by occupational neurosis, large family in Russia to support'', who is finally adjusted by being given work as a porter; to Aimée Prevost, who is the ''heroine of a series of feigned suicides, whom the doctors called psychopathic personality, and who drifted away from the hospital; to Emma Marling, the ''overworked young mother harassed by scolding husband''; to Alice Nardini, ''a wayward syphilitic girl married to a black sheep; in the end a devoted mother''; and to many others, a hundred all told, whose human and medical problems enlisted the interest and efforts of psychiatrist and social worker. To those who, like the reviewer, have lived and worked in the Boston Psychopathic Hospital, the cases as they are recorded bring to memory the magic of the days when Southard reigned there—a busy place into which there poured a stream of hapless, helpless folk whose woes and disabilities made a representative cross section of the Kingdom of Evils.

The cases are presented in three books. The first, *The Three Major Spheres of Social Work, Public, Social, Individual,* tells of Agnes Jackson, a pathetic nuisance, whose problem embraces all three categories; of Richard Sully, a morbid altruist whose difficulties are public and social; and so on. Just here a difficulty presents itself to the reviewer, for it is not clear what distinction is to be made between public and social, and how any case can fail to be ''individual'' in its difficulties except in so far as one assumes a normal person caught in the swirl of adverse circumstances. Though one may quarrel with the separation of cases into these spheres (and the reviewer here records his difference of opinion), yet these cases are clearly presented and their treatment and fate candidly outlined.

Book two, *The Five Major Forms of Evil in the Regnum Malorum,* introduces us to the scheme underlying the title of the book. The evils are *morbi* (disease), *errores* (bad training), *vitia* (vice), *litigia* (law's entanglements), and *penuriæ* (poverty). The cases are presented according to the number of these elements that enter into them. Thus ''Rose Talbot, a highly intelligent delinquent (M. E.

V. L. P.), as the initial letters indicate was an intricate tangle of *morbi, errores, vitia, litigia,* and *penuriæ*—sick, poorly trained and educated, with vices and bad habits that entangled her in the law's meshes and poverty blackening the entire picture. Naturally there are those in whom all these constituents of the Kingdom of Evils are not present, and so we meet "John Flynn, industrial traumatic neurosis" (M. L. P.); "Eliot Calderwood, so-called little fiend, quite amenable" (E. L. P.); Kevork Ardinian, "work-or-fight" case whose problems are M. L.; and finally such cases as those of Clara Perkins, fabricator, mother of illegitimate children, who is declared to be the victim of V. (or vice), and Margaret Dolan, poor, old, and overworked, whose trouble is that only of poverty (P.). We defer a discussion of these forms of evil at this point because the authors (though Southard is undoubtedly the creator of the scheme) do not discuss it until Book IV.

Whatever else *The Kingdom of Evils* does or does not do, in its third part it sets forth, for the first time in the history of psychiatry, the social consequences of mental disease. Seven individuals with syphilopsychoses are depicted, not for their psychiatric or neurological significance, but for their social significance. We see them as they fail in their work or become changed in character, as they enter into police records, as they cause industrial accidents, as they become monkey wrenches in the social machinery. The hypophrenoses (feeblemindedness) enter the lists of social maladjustment, not as adequately as their numbers warrant, but sufficiently to indicate that society owes part of its difficulties to the fact that some of its members are too "simple-minded" to keep up with its complexities. The epileptoses (epilepsies) come in for their bow on the stage of the Kingdom of Evils in the persons of five patients, one of whom developed epilepsy after alcoholism, another who killed his mother in a psychical equivalent, a third who caused difficulty in the army after being drafted, and two others whose attacks appeared to arise after inoculation in the army. (In the case of the last patient there is evident a somewhat too hasty conclusion that a patient is "better" because he improves for a time. He is cited—in 1918—as reduced in the number of attacks, whereas he is now—1922—as badly off as ever.)

King Alcohol and his allies in mischief, the narcotic drugs, are cited in the pharmacopsychoses as responsible in the main for the psychoses of a group of patients. Here we find it emphasized that alcoholism in itself is not psychiatric, a truth that needs to be hammered home to the minds of those who study heredity and class all alcoholism as neuropathic. Here we also find it emphasized that some alcoholism is neuropathic, and that the alcoholic psychoses are respon-

sible for tragedies of all kinds, from the impoverished home to the murder done by an alcoholic paranoiac. There is a wise sanity evident in the chapter dealing with alcohol and the alcoholic psychoses which the reviewer applauds the more heartily and the more enthusiastically because it is so rare in psychiatry and social work.

And so *The Kingdom of Evils* portrays, with emphasis on fact and much pertinent discussion of theory, the rôle of the encephalopsychoses (organic brain diseases), the somatopsychoses (body diseases), the geriopsychoses (senile psychoses) in their relation to social situations. Then the authors discuss the schizophrenoses (dementia praecox), the cyclothymoses (manic-depressive insanity), the psychoneuroses, and the psychopathoses. The medical point of view is stressed only as to diagnosis; for the rest the consideration of the case is largely from the point of view of the social worker and society. Though a philosophy is hinted at as behind the case presentation, it is mainly narrative, with some running comment, a sort of exhibition without profound analysis.

It is in Book IV, labeled *Epicrises,* that we come to grips with belief and theory. Southard claims much for psychiatry, but not too much. "When, therefore, we say we want to apply the psychiatric insight to practically the entire human world, we are not at all asserting or suspecting that the majority of human beings are in any sense psychopathic. We believe that more of the psychiatric point of view will be of great service to the world, as well in domestic as in political life. Just as James gave new viewpoints concerning the religious ecstasy, and just as Hippocrates and Galen before him were physicians who made the most extraordinary contributions to our knowledge of temperament, so we hope by the spread of the mental-hygiene point of view and the point of view of psychiatric social work to aid the common man and woman to deeper practical insights into everyday questions." With this as a program of psychiatry and psychiatric social work, the book emphasizes the value of individual study, the analysis of character as the start of an "inductive study which if carried on sedulously will react upon sociology itself and therefore upon political science, economics, ethics, and the rest of human interest".

There is a brief—to the reviewer unconvincing—statement of the reasons for the scheme of Book I, the division of cases according to the public, social, and individual spheres involved, which Southard ascribes to the influence of Professor Roscoe Pound. The argument for the division of the Kingdom of Evils into five types, the arrangement underlying Book II, is more interesting. Not too much is claimed for the division into *morbi, errores, vitia, litigia,* and *penuriæ.*

Pragmatism is the keynote of the Southard philosophy on this matter—"some division of data is better than no division". And Southard must have had his tongue in his cheek when, on page 391, he points out very gravely that it is very convenient from a mathematical point of view to deal with five divisions, rather than with four, six, or seven. The reviewer predicts that some other reviewer, who has not known the senior author of this book, will wax sarcastically indignant at a mathematical defense of the division of the evils of the world. But even an enemy or opponent will find it difficult to take seriously the *sinister* analysis of facts upon one hand, as outlined on page 393.

Southard rightly insists that we are not as yet ready to place ignorance and vice (*errores, vitia*) among diseases (*morbi*). Though some ignorance, some vice, is basically mental disease, perhaps the largest part is individual and social maladjustment, a wrong position of the gears of life rather than bad gears. And Southard dreams of the doing away of poverty through the unlocking of cosmic energies of research. We do not share his optimism in this regard and we feel that he has not deeply enough analyzed *penuriæ*. No one can disagree with the statement, "Man can no doubt form character more easily than he can reform character." The value of true education in a program of mental hygiene is well stated, though the place of ignorance in mental disease is, I believe, underestimated in this book. In fact, though useful as a division, it is well to remember that at no point can we separate disease, ignorance, crime, legal entanglements, and poverty from one another. Somewhere in the history of each disease is ignorance, crime, bad legislation, and poverty, and so with each of the constituents of the Kingdom of Evils.

The reviewer skips with a sigh the discussion of the nature of the evils or the analysis of history and historic movements on the basis of any pentad of evils or any psychopathic criteria. Too often does a man state the limitations of his science or art and then immediately overstep them. The chapter that deals with Book III commands our interest in its differentiation between the study of insanity and psychiatry, between the alienist and the psychiatrist. Southard brings to the lay worker and reader, as well as to the medical profession, the distinction between insanity as a legal pronouncement and mental disease as a medical diagnosis—between the alienist, who is to discriminate as a public official between sanity and insanity, and the psychiatrist, who is to discriminate between, treat, and study mental diseases. To the reviewer this differentiation is a happy one provided it will progress to the point where sanity and insanity will disappear from the thought of mankind; where the psychiatrist will have no

colleague, the alienist; where if legal entanglements arise, the expert will not be asked as to sanity and insanity—two nonexistent entities—but will be asked to diagnose the mental disease present and to state whether or not the law needs to act to protect society and the patient.

As psychiatrist Southard, as social worker his colleague, Jarrett, present the effects seen in society because of the mental disease of individuals. Obviously it is not sufficient to say that a man is insane or mentally sick; whether insane or not, it is necessary to add a diagnosis. Why? Say the authors, in effect, the social worker must deal differently with a dementia-praecox patient than with an epileptic, even though both break up the furniture or are thrown out of employment. If a patient be syphilitic, an issue is raised that is peculiar to syphilis—namely, has he infected his family?—and it becomes the bounden and sacred duty of psychiatrist and social worker to arrange for their examination and treatment as well as for the patient's treatment. Two men are paranoid, but one is so as the result of alcohol and the other because of a defective germ plasm; the social treatment is totally different in each case. And in dealing with any situation in which mental disease figures, the rôle of the psychiatrist is such that he must determine social treatment by his diagnosis, and that is why Book III of *The Kingdom of Evils* is all-important.

The last chapters of *The Kingdom of Evils* need no special analysis. They are useful and authoritative statements on the application of mental hygiene in the great war and in industry, on the use of technique of out-patient service, on psychiatric social work, its history and evolution. There is an interesting note by Roscoe Pound on legal entanglements, and there are appendices that deal with social records, social-service forms, and legislation in regard to mental disease. All these are of value, and especially is the article on legislation, by Frankwood E. Williams, of great value since very few know or care about the laws that govern psychiatric hospitals. Most of the chapters thus hastily mentioned are evidently written by the literary executors of Southard.

One wishes with Cabot, in his fine introduction, that Southard had lived to rearrange and condense the book. It seems as if Book IV should really have been incorporated as part of the other books, that its philosophy should have permeated their narrative; much repetition would thus have been avoided. There is much to criticize in this great book—from the title, which is more literary than descriptive or definitive, the quotations from Job that head its books, to the division of evils given so prominent a place in both the space and the thought of the book. It may be said by some, and with much truth, that the greatest evils of all, the disharmony existing between

man's nature and man's lot, between desire and taboo, between instinct and inhibition, the antagonism between the individual and the society man has created, are given no place at all. To this it might be replied that these evils are not a part of a social-psychiatric analysis, but belong to the psychopathologists and those who deal with the intricacies of the mental life of man. It does no injustice to the dead leader to admit that his book has great faults and some that were inherent in his nature. There was in Southard an eternal child, whose eager mind, finding new ideas, played with them, arranging and rearranging them as if they were toys.

But all these faults are as nothing to the virtues of the book. Whether we call it *The Kingdom of Evils* or *Psychiatric Social Work,* the fact is not altered that it presents the union of psychiatry and social work as no other book even begins to do. Whether we cavil at quotations from Job or find them appropriate is not pertinent to the fact that here psychiatry leaves its fastnesses in the asylums of the world and brings its knowledge to bear on the evils of life, and brings the evils of the world to bear on its own knowledge. For if the psychiatrist has something that he can teach to social worker, lawyer, judge, warden, and military man, he has much to learn from them to round out his psychiatry, and this is emphasized continually in *The Kingdom of Evils.*

From now on it should be impossible for society to do without the psychiatrist and for the psychiatrist to do without the social worker. From now on no hospital for mental disease but must have an outpatient department reaching out into its community, accessible to the community, acting as a great consulting room to court, social agency, and the harassed individual. But also it must organize a department of social work, to penetrate into the community, to act as an avenue of information, an avenue of operation, to bring the community to the hospital and the hospital to the community, to represent the psychiatrist to the patient and the patient to the psychiatrist. The social worker, properly viewed, and as represented in Southard's Jarrett, is no mere subordinate of the medical man—she is the great intermediate professional, linking him to the community, so that he as well as she may properly serve it.

Abraham Myerson.

Tufts Medical College.

Mental Diseases: A Public Health Problem. By James V. May, M.D. Boston: Richard G. Badger, 1922. 544 p.

Whatever can aid in giving a wider appreciation of the important part that mental disorders play in our civilization must commend itself to the readers of Mental Hygiene. Those whose main interests

lie in the field of psychiatry are familiar with a large amount of information that, could it gain more general attention, would arouse the public to an appreciation of the causes and nature of many of the social and health problems that are troubling our civilization. Much of this information is already in print, but lies buried in textbooks of a highly technical quality, or is so scattered through the literature as to be inconvenient for reference, or lacks an effectively coördinated presentation. With this in mind, Dr. May has given us the present volume.

The author brings to his task a rich experience with mental disorders in varied relations, accumulated during his work as physician and medical superintendent in hospitals in New York and Massachusetts, two states that have evolved exceptionally high standards in the care and treatment of the mentally disordered. As a commissioner of the state hospitals of New York, he had unusual opportunities to become familiar with problems of administration and legislative policies as they concerned the state as a unit. He is well known as one who has had a deep interest in the study of the statistics of mental disorders, and as having done much to promote coöperation among hospitals in their medical work. These qualifications of the author and an attractive method of presentation make this book one of authority and interest.

The contents are arranged in two divisions. The first is devoted to a general consideration of mental disorders as social problems, and the second to a consideration of the special clinical groups and types in which mental disorders occur.

The first chapter presents an array of statistical data, critically selected from authoritative sources, to show the economic and social importance of mental disorders. To emphasize his thesis that mental disorders are problems of public-health concern, the author discusses the statistics he presents in comparative relations with those of somatic diseases that are recognized as public-health problems and for which active efforts at prevention and regulation have been made. Two other chapters bear on this general social aspect. In one the relation of immigration and mental disorders is considered, and in the other the interrelation of the abnormal and diseased mind with problems of criminal responsibility. This latter chapter is one of convenient reference for those who discuss problems of behavior in the effort to secure a better recognition of these interrelations by courts and public officials, and brings together into one coördinated presentation a great deal of information that lies widely scattered.

Those who are interested in securing proper legislative provisions for the care of the mentally disordered, and in the problems that a

state must consider in providing adequate modern facilities, will find helpful suggestions in the chapters on legislation and methods of hospital administration. These contain an exeellent eoneise narrative of the history of the development of hospitals for the mentally disordered and of legislative policies. These form the background for a description of modern methods of treatment and administration in hospitals of high standards. It is an account of what has been done by the more progressive states of this country and should be an ineentive to the improvement of the deplorable conditions that still exist in many states in which hospital facilities and legislation are far below modern standards.

One of the speeial features that has eharaeterized psychiatrie progress in this country in reeent years is the effort to make the technical information accumulated in this field more widely available in public serviee. Several specific developments are the outgrowth of this spirit. The most noteworthy are the establishment of psyehopathie hospitals, the mental-hygiene movement, and the part that neuropsychiatry played in the recent war. The elose relations that the author has had with eaeh of these developments gives great value to his diseussions of them, in a series of speeial chapters, and adds to the book's comprehensive presentation of the field of modern psychiatry.

A chapter devoted to endoerinology and psyehiatry is very helpful at the present time in furnishing a eoneise survey of modern trends of thought in this field. The introduction, into a book primarily dealing with psychiatry, of the diseussion of a subject so speeifieally one of general medical interest shows how closely modern psyehiatric problems are eonnected with the general field of medieine and physiology.

The final chapter of the first division of this book is devoted to a consideration of the elassification of mental disorders. Few subjects of psychiatric interest have been more prolific of diseussion during the progress of psyehiatry than those of classification and terminology. While the nature of the problems involved in nosological distinetions prevents any possibility of finalities or ultimate perfeetion, constructive progress can be greatly aided by a common understanding of descriptive terms. Until recently, the experiences of hospitals for mental disorders were reported in varying ways, representing different eoneeptions of values, and thus have been unusable for purposes of compilation and correlation. Within the last few years an effort has been made to secure a eoöperation in the aeeumulation of data that might form the basis for building up a knowledge of existing conditions. The adoption, by a large majority of institutions and organizations working with psychiatric problems, of a uniformity in their statistieal work promises mueh for a better understanding of

the part mental disorders play in our social life and makes it possible to judge as to the efficiency of our present methods. This scheme of classification is fully described by the author and forms a guide that will be of help to those who are working with clinical problems.

The second division of this book is devoted to clinical psychiatry. In this the author discusses the various clinical groups and types in which mental disorders occur.

The method of presentation followed is such as to make special comment or criticism of theories or conceptions uncalled for. The author brings together in his discussion a critically selected material drawn from many sources and arranged to present a systematic treatment of each topic. It thus is representative of the best thought and contributions on each subject. Particular consideration is given to the historic development of the conception of each clinical type, and throughout the discussion the author consistently keeps in mind the public-health relations of each disorder.

Dr. May clearly states in his preface that the book is not intended to be used as a textbook. As one becomes familiar with its contents, one cannot avoid the belief that the final results of his work have given to us a book that has a most needed place in the teaching of psychiatry. For the medical student, as a book to follow during his college course of instruction, it needs supplementing by one in which emphasis is placed upon the concrete clinical facts with which the physician must be concerned, such as case descriptions, symptomatology, interpretation, and treatment. It will, however, be for him a helpful book of reference, the more so as he becomes interested in the relations of mental disorders to social and behavior problems. But psychiatry has relationships in college instruction that are not specifically medical. Such are those that must be considered in courses in sociology, economics, and legal relations. In all of these Dr. May's book should have a foremost place.

The book gains distinction from an introduction written by Dr. Thomas W. Salmon, whose rich experience with mental disorders in broad relations, in connection with his work with The National Committee for Mental Hygiene, qualifies him to speak of its merits with authority.

One may fairly state that in no one book in English hitherto available can there be found such a well-selected assemblage of information that is needed to give a comprehensive survey of the social and administrative relations of mental disorders. It forms a valuable handbook of reference for all who are interested in institutional work, in public administrative matters, or in the wide field of abnormal behavior.

A. M. Barrett.

State Psychopathic Hospital, Ann Arbor.

Benign Stupors. By August Hoch, M.D. Edited by John T. MacCurdy, M.D. New York: The Macmillan Company, 1921. 284 p.

Thorough studies of this kind are rare in all branches of medicine. It is, therefore, gratifying to those interested in American psychiatry that this valuable volume should appear at this time. Clinical psychiatrists will find it necessary to be conversant with its contents in order to have a proper understanding of a group of cases that heretofore have been very inadequately treated in the field of psychiatry.

For an appreciation of the true value of this contribution to psychiatry a certain perspective is necessary. More than twenty-five years ago, Kraepelin's clinical groups of manic-depressive insanity and dementia praecox, among others, came into being. These diagnostic groups, as is well known, were based on observed symptoms. Among these symptoms, negativism, resistance, apathy, and stupor became irrevocably associated with dementia praecox. The search for so-called pathognomonic symptoms was carried on to an extreme degree, not only in Germany, but also in this country; and so when any of these symptoms was found, psychiatrists investigated no further, but rested with the diagnosis of dementia praecox.

Fortunately this restricted psychiatric outlook has not endured in America; but while it was in vogue, it made a deep impression upon the minds of psychiatrists, and for that reason benign stupors, as described by Hoch, have heretofore been associated in the minds of most psychiatrists with dementia praecox, especially the catatonic form. Doubtless thousands of cases throughout the country have been so designated. Doubt has been cast upon the genuine recovery of any of these cases. Indeed, during the pre-Kraepelinian period, stupors appear to have been more clearly understood than in later days, as indicated by the review of the literature in the concluding pages of this book.

Careful clinical observation, particularly by Kirby of the Psychiatric Institute of New York, brought about a change in the interpretation of these cases. In 1913, Kirby called attention to their benign character and suggested that they bore a relationship to manic-depressive insanity, although having a certain similarity to the catatonic form of dementia praecox.

Hoch and MacCurdy, with Kirby's study as a background, have now submitted a detailed and exhaustive study of benign stupors. They establish the stupor reaction as a distinct clinical entity. They describe a definite symptomatology. They indicate the thought content, in so far as a thought content can be said to exist in these conditions. They interpret the meaning of the reaction and, what is of

great significance, they show quite clearly that these benign stupors are all a part of manic-depressive insanity.

Their observations are ably illustrated by a number of case histories. Their conclusions constitute one of the most stimulating contributions to psychiatry that has appeared in recent years. Their method of presenting the subject is one that might be emulated by other writers in psychopathology.

In their typical cases, the cardinal symptoms are as follows: *Lack of affect* is most important. These patients are remarkably apathetic, and when the stupor is deep, practically no emotional response can be elicited. This apathy is to be distinguished from the depressive affect that exists in retarded depressions. *Inactivity* is another cardinal symptom. There is almost complete cessation of speech and of spontaneous muscular activity. *Catalepsy* may accompany this state, and *negativism* frequently exists to a marked degree. Another outstanding symptom is *interference with intellectual processes* to such an extent that the mind seems almost a blank. Memory is in abeyance even for striking experiences that may occur during the psychosis. The thought content, which may be gathered at the onset or during interruption, shows a peculiar preoccupation with the *theme of death,* which is not merely a dominant topic, but one of almost exclusive interest. Finally, certain *physical symptoms* accompany this stupor, such as skin and circulatory anomalies, loss of weight, and menstrual suppression, and a low fever may occur.

The symptoms enumerated above the authors believe to be quite as distinctive of benign stupors as flight of ideas, elation, and pressure of activity are of the manic state.

An extremely interesting part of the study is that which has to do with thought content. It is true that active mentation does not take place throughout the stupor, but by a study of many cases, all showing practically the same general trend of thought, particularly by a study of the onset, by retrospective accounts, and by observations during the stupor, the characteristics of the thought content have been made clear.

The authors have shown that these patients are preoccupied by one dominating topic—namely, the theme of death. They believe themselves either dead or about to die. They are in heaven or hell. They wish death, and even make suicidal attempts. In whatever form this theme is symbolized, ideas of death are the outstanding trend of thought—just as depressed cases are preoccupied to a great extent with ideas of unworthiness and sadness, and manic states with thoughts of power accompanied by elation.

Since death and rebirth ideas exist so universally in man's mental

history, it is perhaps not remarkable that these ideas should be utilized by patients in benign stupors. In any case, this is what the authors have found to be true. Their observation offers a very interesting instance of how psychopathology and ethnology are inseparable in their expression.

A study such as the above represents infinitely more time, attention to detail, and thought than a few paragraphs of review can indicate. In addition to what has already been discussed, every phase of benign stupors is dealt with. This includes diagnosis, treatment, malignant stupors as contrasted with benign stupors, physical manifestations of stupor, special cases, and, in closing, a review of the important literature on stupors.

Sanger Brown, II.
New York State Commission on Mental Deficiency.

Psychoanalysis and the War Neuroses. By S. Ferenczi (Budapest), Karl Abraham (Berlin), Ernst Simmel (Berlin) and Ernest Jones (London). Introduction by Professor Sigmund Freud (Vienna). London: The International Psychoanalytical Press, 1921. 59 p.

The war has had the effect, not only of arousing interest in nervous and mental disorders, but also of modifying the views held in regard to their etiology. On the one hand, it has led to a fairly general recognition of the importance of the psychogenic factor, and to this extent has been a victory for the Freudian school. On the other hand, it has, in the eyes of many, tended to discredit at least one of the principles of psychoanalysis—namely, the principle "that the driving forces which find expression in the formation of symptoms are sexual in nature, and that the neurosis is the result of the conflict between the ego and the sexual impulses which it has repudiated". This little book—consisting of four papers, three of them read at the Fifth International Psychoanalytical Congress, held in Budapest in 1918, and one, that by Ernest Jones, read before the Royal Society of Medicine, Section of Psychiatry, in the same year—is of interest as an expression of the reaction of Freud and his followers to these new facts which the war has brought out and to the opinions to which they have given rise.

The first paper, by Dr. Ferenczi, is "a critical survey of the literature on the war neuroses from the standpoint of psychoanalysis".

With the war there flamed up the controversy as to the nature of the traumatic neuroses—whether they were of psychical or of physical origin—a controversy in which those favoring a psychical explanation were unquestionably the victors. This being established, the

quarrel lay from now on between the supporters of the various psychological theories. Ferenczi reviews the various theories put forward and points out that they constitute an advance toward the teachings of psychoanalysis. At the same time, as more or less representative of the views of neurologists who up to a certain point have accepted the psychoanalytical point of view, we get the statement of Nonne that "Freud's idea of the almost exclusively sexual foundation of hysteria has been conclusively disproved during the war". To which Ferenczi replies, "We can no longer leave this unanswered which after all is only a partial denial of psychoanalysis; also we can very easily give the answer. The war neuroses, according to psychoanalysis, belong to a group of neuroses in which not only is the genital sexuality affected, as in hysteria, but also its precursor, the so-called narcissism, self-love, just as in dementia praecox or paranoia. I grant that the sexual foundation of the so-called narcissistic neuroses is less easily apparent, particularly to those who equate sexuality and genitality and have neglected to use the word 'sexual' in the sense of the old Platonic Eros. Psychoanalysis, however, returns to this extremely ancient standpoint when it treats all tender and sensual relations of the man to his own or to the opposite sex—emotional feelings toward friends, relatives, and fellow creatures generally, even the affective behavior toward one's own ego and body—partly under the rubric 'erotism', otherwise 'sexuality'."

In the paper by Dr. Abraham, this narcissistic theory is further elaborated. Why, he asks, is the predisposition to break down as a result of trauma greater in some than in others? Those who broke down were as a rule "labile people" before the war, especially as regards their sexuality. "In all of them, sexual activity was diminished, their sexual hunger (libido) being checked through fixations; in many of them already before the campaign potency was weak or they were only potent under certain conditions. Their attitude toward the female sex was more or less disturbed through partial fixation of the sexual hunger (libido) in the developmental stage of narcissism. Their sexual and social capacity of functioning was dependent on their making certain concessions to their narcissism.

"In the war these men were placed under completely changed conditions and in the face of extraordinary demands. They had always to be prepared for unconditional self-sacrifice in favor of the mass. This signifies the renunciation of all narcissistic privileges. The healthy person is able to accomplish such a complete suppression of his narcissism; he loves according to the transference type and so is capable of sacrificing his ego for the whole. In this respect those disposed to neuroses are inferior to healthy persons."

The paper by Simmel deals with his experience in treating war neuroses. His treatment consisted of "a combination of analytical-cathartic hypnosis with analytical conversations during the waking state and dream interpretations carried out both in the waking state and in deep hypnosis". With this method a relief of symptoms was brought about in two or three sittings on an average. He found that the unconscious meaning of the symptoms was "for the most part of a non-sexual nature, there being exhibited in them all those war-produced affects of terror, anxiety, rage, etc., associated with ideas corresponding with the actual occurrences of the war". Simmel does not conclude from these facts, however, that the war neuroses have not a sexual basis. "The fact that in the midst of the selfsame experiences one soldier remains well while another becomes a neurotic may, so far as my experience goes, be very well connected with the psychosexual constellation of the particular individual."

Ernest Jones, in his paper, in which he attempts to harmonize the facts brought out by the war with Freud's theory of the neuroses, expresses views more or less similar to those of Ferenczi and Abraham. He frankly admits that Freud's theory has not yet been proved true in the case of the war neuroses. This, however, is quite another matter from saying that it has been disproved. "The matter is at present *sub judice* and must remain so until sufficiently extensive investigations shall have settled the question one way or the other." However, although nothing is yet proved, the psychoanalyst should be able to formulate "some tentative conception of the relation between the phenomena commonly observed in the war neuroses and the psychoanalytical theory". He here undertakes to formulate such a conception.

There is in all of us a conflict between the conscious ego on the one side and various impulses and desires on the other, out of which, after a series of partial renunciations and compromises, an adjustment of some sort is reached. In warfare new conditions and new standards of conduct obtain; impulses previously held in check—impulses to cruelty, for example—are released, and a new adjustment therefore becomes necessary. "When the old adjustment between the ego-ideal and the repressed impulses is taken away, it may prove impossible to establish a fresh one on the new conditions, and then the repressed impulses will find expression in some form of neurotic symptom."

But aside from this question of war adaptation, we have also that of fear. "The latter is hardly to be regarded as a sub-group of the former, inasmuch as there is no readjustment or transvaluation of values concerned, as there typically is with the former. The moral attitude toward fear and the conflicts arising in connection with it

remain the same in war as in peace." How, then, is this fear to be explained? "The reaction to external danger consists normally of a mental state of fear . . . and in various activities suited to the occasion—flight, concealment, defense by fighting, or even sometimes by attacking. On the affective side, there is, to begin with, a state of anxious preparedness and watchfulness, with its sensorial attentiveness and its motor tension. This is clearly a useful mental state, but it often goes on further into a condition of developed dread or terror which is certainly the very reverse of useful, for it not only paralyzes whatever action may be suitable, but even inhibits the functioning of the mind, so that the person cannot judge or decide what he ought best to do were he able to do it. The whole reaction of 'real' fear is thus seen to consist of two useful components and one useless one, and it is just this useless one that most resembles in all its phenomena the condition of morbid anxiety." Jones infers, therefore, that this useless component "is not part of the useful biological mechanism of defense, but is an abnormal response akin to the neurotic symptom of morbid anxiety".

Now practically all modern investigations into the pathogenesis of morbid fear "agree that it stands in the closest relation with unsatisfied and repressed sexuality", and "Freud has made the striking suggestion that the developed dread sometimes found in situations of real danger is derived, not from the repressed sexual hunger that is directed toward external objects, as in the morbid anxiety of the peace neuroses, but from the narcissistic part of the sexual hunger that is attached to the ego". Jones, therefore, "ventures to suggest that we may here have the key to the states of terror with which we are so familiar in the war neuroses", and reaches "the comforting conclusion that a normal man would be entirely free from dread in the presence of any danger however imminent, that he would be as fearless as Siegfried".

One wonders how Dr. Jones would apply this theory to the facts of animal psychology. We not infrequently see animals, horses for example, overcome by terror which, as in the case of men, "is certainly the reverse of useful" and which "paralyzes whatever action may be suitable". Would Dr. Jones explain this reaction on the part of a horse in the same way as he does a similar reaction on the part of a man? Would he regard the dread displayed by the horse which "is not part of the useful biological mechanism of defense" as due to unsatisfied narcissistic hunger, and would he reach the same "comforting conclusion" that a normal horse "would be entirely free from dread in the presence of any danger however imminent, that he would be as fearless as Siegfried"?

The introduction, by Freud himself, may logically be considered

last, since in it are summed up the views expressed by the other writers. Freud grants, as does Jones, that the sexual-hunger (libido) theory of the neuroses has not been proved as regards the war neuroses, and also lays great stress on the fact that neither has it been disproved. He believes that there is a correlation undoubtedly subsisting between shock, anxiety, and narcissistic sexual hunger (libido).

"The theory of the sexual etiology of the neuroses or, as we prefer to call it, the sexual-hunger (libido) theory, was originally put forward only as regards the transference neuroses of peace conditions, and can easily be demonstrated in them by using the analytic technique. But its application to those affections which more recently we have grouped together as the narcissistic neuroses meets with difficulties. Ordinary cases of dementia praecox, paranoia, and melancholia are fundamentally very unsuitable material for the proof of the sexual-hunger (libido) theory and for reaching an understanding of it, for which reason psychiatrists who neglect the transference neuroses cannot be reconciled to it. The traumatic neuroses (of peace time) have always been reckoned to be the most refractory in this respect, so that the appearance of the war neuroses does not add any fresh factor to the former situation.

"Only by advancing and making use of the idea of a 'narcissistic sexual hunger (libido)'—that is to say, a mass of sexual energy that attaches itself to the ego and satisfies itself with this as otherwise it does only with an object—has it been possible to extend the sexual-hunger (libido) theory to the narcissistic neuroses, and this entirely legitimate development of the concept of sexuality bids fair to do for these severer neuroses and for the psychoses all that one can expect from an empirically and tentatively progressing theory."

This broader concept of sexuality on which the psychoanalyst so strongly insists may be, as Freud says, entirely legitimate, but it is rather hard to see just how it enables us to establish a sexual basis for the war neuroses along the lines of psychoanalytical theory. It is a principle of psychoanalysis, as stated by Jones in the present volume, that the wish that leads to the creation of the neurosis is an unconscious one—"the wish producing the neurosis is one that is not in harmony with the ego-ideal and that is therefore kept at as great a distance as possible from it". So it would appear that if the love of the individual for himself, his parents, and his fellow men, is to serve as an etiological factor in the production of the neurosis, it must, according to the psychoanalytical theory, be a force that conflicts with the ego-ideal, a force, therefore, of which the individual is not conscious. Now the love of man for his fellow men and of a child for his parents is universally regarded as a virtue, and as far as self-

love or regard for one's own welfare is concerned, if not regarded as a virtue, it is at least accepted as a natural tendency common to all men, the absence of which in any individual would be clear evidence of abnormality.

Those forms of love for one's self or for one's fellows which the psychoanalyst has taken in by broadening his conception of "sexuality" do not, therefore, conflict with the ego-ideal, nor are they crowded back into the unconscious. The forms of love that are looked upon as immoral, and that therefore conflict with the ego-ideal so that they are likely to be repressed, are with few, if any, exceptions those that we look upon as "sexual" in the old narrow meaning of the word, and it is therefore such forms of sexuality only that, according to the principles of the psychoanalytical theory, can give rise to a neurosis. Since, then, it is only these forms of sexuality that can give rise to a neurosis, it is not quite clear how broadening the meaning of the term can enable us to find a sexual cause for those forms of mental and nervous disorder in which no such cause could otherwise be found. It would almost seem as if the psychoanalyst had here fallen into the logical error of carrying over into the broader meaning of the term "sexuality" an implication that belonged only to that narrower conventional meaning which he had discarded; that, in short, he was giving the word "sexual" a very broad meaning in order to demonstrate the existence of a sexual wish and then falling back on the old narrow meaning of the term in order to make of this wish something that might serve as the dynamic factor lying back of the neuroses.

The concept of "sexuality" has been broadened to include "narcissistic sexual hunger", but no explanation is offered of how this "narcissistic sexual hunger" comes into conflict with the ego-ideal and of how, therefore, it can be the dynamic factor in the production of the war neuroses. "Narcissistic sexual hunger" is a very fine term, but one might wish that those who use it would be a little more specific in explaining just what it is and how it operates. The term hunger implies always that there is something for which the individual hungers, something wished for or desired. What is this something in the case of "narcissistic sexual hunger (libido)"? In the case of sexual hunger directed toward another individual, whether of one's own or the opposite sex, the wish may be for some form of sensual gratification recognized as sexual in the old narrow meaning of the term, but it is not in this old narrow meaning that the term is here used. One who loves another may also wish to have his love reciprocated or to have his loved one always with him, but the narcissistic lover has this advantage over all others that he can never by

any possibility suffer from unrequited love, nor can he ever be separated from the object of his regard. One may also desire the happiness and well-being of his loved one, and it is of course true that under war conditions the soldier may be obliged to place service to the group before his desire for his own welfare, which, as every one admits, does give rise to an emotional conflict. But although he may be unable to gratify it, the soldier does not therefore look upon his wish for his own welfare and safety as in any sense an ignoble or an improper one; it does not conflict with his ego-ideal, and, speaking from personal experiences of life at the front under shell fire, the reviewer might say that one is seldom unconscious of this wish. What, then, is the nature of the narcissistic wish which the soldier is unable to gratify, of which he is unconscious, and which therefore is capable of giving rise to a neurosis? The question is one in regard to which the advocates of the "narcissistic sexual-hunger (libido)" theory have very little to say and which we would like to have answered.

Our review of this book would be incomplete if it dealt only with the reaction of its authors to the facts brought out by the war neuroses and neglected to make any mention of their attitude toward those whom they look upon as their opponents. With the exception of Dr. Simmel's paper, we find displayed throughout the tendency, so prevalent amongst psychoanalysts, to charge those who differ from them with intellectual dishonesty and ignorance. Freud speaks of "the opponents of psychoanalysis, whose repugnance to sexuality has shown itself to be stronger than their logic", and Jones asserts that those who deny the doctrines of psychoanalysis, and who presumably have never themselves employed any method that gives access to the unconscious, are "in a very similar position to the individual who on *a priori* grounds would deny the details or even the existence of histology without having looked through a microscope, the only avenue to histology".

"Many medical men", says Freud, "who had previously held themselves aloof from psychoanalysis have been brought into close touch with its theories through their service with the army compelling them to deal with the question of the war neuroses. . . . Some of the factors, such as the psychogenetic origin of the symptoms, the significance of unconscious impulses, and the part that the primary advantages of being ill plays in the adjusting psychical conflicts ('flight into disease'), all of which had long before been discovered and described as operating in the neuroses of peace time, were also found in the war neuroses and almost generally accepted. . . .

"From the advance thus made towards psychoanalysis, however,

one need not assume that the opposition to it has been reconciled or neutralized. One might think that when a man who had hitherto not accepted any of a number of connected conclusions suddenly finds himself in the position of being convinced of a truth of part of them, he would weaken in his opposition and adopt an attitude of respectful attention, lest the other part, of which he has no personal experience, and therefore upon which he is unable to form a personal opinion, should also prove to be correct."

Freud's position is cleverly taken and is without doubt more or less justified as regards certain of his opponents. There are, however, others who might reply that they had already held views before the war which in some respects were in agreement with those of Freud, although they had been unable to accept his theory that the driving force lying back of the symptoms was in every case of a sexual nature. Such individuals might well claim that the war neuroses had simply afforded additional evidence in support of an opinion that they had held right along. And of the converts whom the war won over to a similar opinion, not all came from the ranks of those who before the war had denied the existence of psychogenic factors in mental disease. Some at least were men who had previously accepted the doctrines of psychoanalysis in their entirety, but now felt it necessary to modify their position somewhat.

It is an unfortunate thing that the psychoanalyst should adopt such an intolerant and partisan attitude towards those who differ from him. Undoubtedly it is partly due to the fact that in the past he has encountered much unjust criticism that had its roots in prejudice and ignorance. At the present time, however, here in America at least, there are comparatively few who refuse to recognize the fact that in the field of abnormal psychology, Freud and his followers have done valuable pioneer work, or who are unwilling to make use of the theory and technique of psychoanalysis, in so far as they find this theory and technique adapted to the problems with which they have to deal.

Milton A. Harrington.

New York City.

Fundamental Conceptions of Psychoanalysis. By A. A. Brill, Ph.B., M.D. New York: Harcourt, Brace, and Company, 1921. 344 p.

In the introduction to this book, Doctor Brill states: "Moreover, the knowledge gained through it [psychoanalysis] is developing a prophylaxis which will not only diminish nervous and mental diseases, but will establish newer methods in our system of education. In brief, psychoanalysis, aside from its therapeutic application, which

is not the object of this work, is of interest to any person who wishes to understand human nature and know himself in the Socratic sense." So, too, Dr. Brill emphasizes constantly throughout his dissertation the necessity of understanding one's self as well as one's relation to society.

As a presentation of the facts, the principles, and the truths of Freud's foundations and mechanisms, this work is unsurpassed, and great credit should be given to Dr. Brill for his tireless efforts to bring this subject in its true form before not only the medical profession, but also the public in general.

The first chapter gives a resumé of the steps taken by Freud and Breuer in the development of the technique that was termed by them the cathartic method. Through this method it became evident that the so-called normality or abnormality of the individual—the question whether he will be able to adjust himself to his environment or will fall by the wayside—depends entirely upon the nature of his early impressions. "Given an average amount of brains, every individual, as he grows up, has certain tracks laid out for him by his environment; he can follow those tracks and those only; if he attempts to get off the track, he finds himself in trouble; he finds himself incompatible with his environment, he collides with his environment. It is thus of great importance to give the individual enough tracks to be able to move freely and at the same time not to come in conflict with his fellow beings. From a very broad experience with nervous and mental diseases, I feel that if everybody would understand this, mothers and teachers particularly, we could reduce nervous and mental diseases as much as we have reduced diseases of smallpox and typhoid. We are not afflicted with these time-old diseases to-day because we know what produces them and have learnt to prevent them. We can do likewise with a knowledge of psychoanalytic principles."

Doctor Brill has then applied the knowledge of psychoanalytic principles to the interpretation of symptoms, their nature and function. Their nature is that of a defense and their function is that of an emotional outlet. The technique of psychoanalysis offers a means whereby the symptom may be understood, and the cure of a symptom would bear a constant relation to the release of the emotion through adequate channels. The mere fact that analyzing an individual is quite different from curing an individual of a disorder should be obvious.

The psychology of forgetting, the psychology of everyday life, and the technique and tendencies of wit are discussed in detail and with clearness.

The chapters on dreams are devoted to an explanation of the functions and motives of our dream life. Many extremely interesting and carefully analyzed dreams are offered to the reader. A careful study of the mechanism of dream states leads one to recognize the very definite and close relation of the dream—as was shown of symptoms, too—to the inner life of the patient. Both dreams and symptoms are "incursions into consciousness from the unconscious", and "it is necessary to get at what we called their 'latent' contents to grasp their essential significance and meaning".

Throughout the book it is demonstrated frequently that much of our conduct reaction and our behavioristic responses bear a close relation to our "love" life, controlled, guided, and directed by our unconscious personality and its relation to our environment.

An excellent description of the only child is given in detail. Dr. Brill says: "The problem is more complicated when we come to prophylaxis in relation to psychosexuality . . . I shall merely say that proper sex regulation does not necessarily imply repression and extermination of all sex feelings, and that the requisites for perfect manhood and womanhood are all the impulses and desires that are normally common to men and women . . . the only child is a morbid product of our present social-economic system . . . by their [parents] abnormal love they not only unfit the child for life's battles, but prevent him from developing into normal manhood, thus producing sexual preverts and neurotics of all descriptions."

The last two chapters, on fairy tales and the selection of a vocation, can best be described in Dr. Brill's own words: "We may thus lay it down as a general principle that all expressions, whether normal or abnormal, as symptoms, dreams, witticisms, fairy tales, and artistic productions, may be classified as infantile or adult, or as auto-erotic or object libido. Inherently, there is very little difference as far as the individual is concerned, but conceived socially, we may say that only those productions that have meaning and effect to others besides the artist or producer himself may be considered normal."

As a presentation of the principles of psychoanalysis as laid down by Freud, the author has given us an excellent expression. He has also offered to the psychiatrist, and to others interested in mental hygiene, an implement of great usefulness. To the student of human nature, to the educator and teacher, and to those whose work brings them in contact with children, this book offers valuable assistance in the understanding of conduct disorders. It is an exceptionally good book.

Frederic J. Farnell.

Rhode Island Society for Mental Hygiene.

The Origin and Development of the Nervous System. By Charles Manning Child. Chicago: The University of Chicago Press, 1921. 296 p.

Individuality in Organisms. By Charles Manning Child. Chicago: The University of Chicago Press, 1915. 213 p.

The principle of functional integration, or the hypothesis that the complex behavior and morphological pattern of an organism are determined by its interaction with its environment, has never met with much favor among biologists because of the lack of a definite and precise theory as to its possible actual operation. In these two little volumes from the University of Chicago Press, *Individuality in Organisms* and *The Origin and Development of the Nervous System,* Professor Child has furnished us such a theory richly supported by experimental evidence accumulated through many years of careful research. In the former, Professor Child has exposed and developed his general thesis, and in the latter he has sought to apply it in explaining a specific problem—that of the evolution of the nervous system. Professor Child has called his theory a "dynamic conception of the individual"—dynamic in opposition to the more prevalent preformistic and vitalistic theories—and has developed the thesis "that the foundation of unity and order in the organic individual is the transmission of dynamic change, 'stimulus', and 'excitation' from one point to another in protoplasm". This excitation is produced by the reaction of a specific protoplasm to the external world, the responses arising in the region of the protoplasm where there is highest metabolic (oxidated) rate and being gradually transmitted to those of lower metabolic activity. The responses of the protoplasm to external (and later internal) stimuli produce regions or zones of metabolic activity to which Child has given the name "physiological gradients". These physiological gradients represent at first purely *quantitative* reactions whose localization and direction may be controlled, as shown by actual experimental data obtained from work with the lower organisms, by modifying the intensity of a stimulus and thereby the metabolic activity of the protoplasm. The effect of the greater metabolic activity of any region in the protoplasm is to differentiate this region or gradient from the remaining mass of protoplasm, and herein lies the origin of the qualitative differentiation of the material of the organism, or what amounts to the same thing, its morphological pattern. The permanency of the physiological gradient established depends upon the duration and the intensity of the metabolic activity induced by the exciting stimuli. If this is so, by controlling and directing these, one ought to be able to modify the morphological development of the individual. This is what Professor Child actually has been able to show

by his own and others' researches in the field of experimental physiology and zoölogy.

Another characteristic of the nature of the physiological gradient is its influence upon the development of other gradients. The gradients of higher metabolic activity exercise a certain inhibition and control over the formation and range of gradients of lower metabolic levels such that a relation of dominance and subordination is established between the levels of high and low metabolic rate. According to the author, "dominance or control of one part over another in the organism is a matter of difference in metabolic rate, the region of higher rate being dominant".[1] The coördination of the activities of the organism, or its physiological individuality, is determined by the interrelation of the dominant gradients. Polarity, for example, is due to the dominance of a single axial gradient; radial symmetry to a series of gradients radiating from or toward the central zone, either the periphery or center being the region of highest metabolic activity. The nervous system in the higher organism is nothing but a continuation of the development "of the primary relation of dominance and subordination existing at the beginning of individuation between regions of high and those of low metabolic rate".[2] In brief, the nervous system and its integrative action is not some new or different mechanism in the development of the individuation of the organism, but simply an evolution of the primary integrative mechanisms of the lower organisms, and it is to the elaboration of this part of his thesis that Child has devoted his entire second volume.

Professor Child's important contribution to the subject should certainly have a wide influence on contemporary biological and psychological theory. If the main point of his thesis is correct—namely, that the physiological individuality of an organism is the result of the interrelation between living protoplasm and the external world—then, as he himself points out, the immutable germ-plasm theory of Weismann must be renounced. We ourselves have never understood why biologists have continued to swallow the germ-plasm theory and its arbitrary distinction between soma and germ, together with the categorical denial of the possibility of transmitted characters, in spite of the evidence produced against it by Von Nageli and Hertwig, and its only redemption for having side-tracked so many promising biologists into spending the most active years of their lives counting chromosomes is their contribution to our knowledge of cellular biology. If, furthermore, as Child has tried to show, "the organism is fundamentally a specific reaction system in which quantitative differences

1 *Individuality in Organisms*, page 37.

2 *Ibid.*, page 61.

initiate physiological individuation, development, and differentiation", we must agree with him that "nothing can be more certain than that it acts essentially as a unit in inheritance", and that "neither characters nor factors as distinct entities are inherited, but rather possibilities which are given in the physico-chemical constitution of the fundamental reaction system, but not necessarily localized in this or that part of it".[1]

Acceptance of this view will do much to offset the influence of some unsupported theories of eugenics such as that advanced by Davenport. The authority of the Cold Spring Harbor School has been much shaken on the statistical side by certain criticisms of Professor Karl Pearson.[2] Professor Child now furnishes an even stronger argument against them from the purely biological side.

Professor Child's contribution, however, is not merely negative, but abounds in many suggestions that will bear fruit both in psychology and sociology as well as in pure biology. To make any reference at all to them in the manner they deserve would prolong very much our review, but we might note in passing that White already has made use of the principle of functional integration as the basis of his new book, *Foundations of Psychiatry*.[3]

Both little volumes are well written, but *The Origin and Development of the Nervous System* will make difficult reading for the non-technical, though educated reader, owing to the rather considerable theoretical biological and physiological knowledge it presupposes. On the other hand, a copious bibliography is appended. We regret, however, to note that, like many American writers who have had training in Germany, Professor Child makes practically no reference to French literature. This is particularly regrettable in this case, as he has thereby omitted all reference to the monumental work on *Chronaxie* by Professor Louis Lapique and his pupils.

David Wechsler.

Bureau of Children's Guidance, New York City.

Nutrition and Growth in Children. By William R. P. Emerson, M.D. New York: D. Appleton and Company, 1922. 342 p.

In the whirlwind of popular interest in nutrition—an interest quite surpassing anything ever exhibited in regard to any legitimate aspect of health work up to the present—this book will be welcome, for Dr. Emerson has had a good deal to do with arousing this popular

1 *Loc. cit.* page 202.

2 *Mendelism and the Problem of Mental Defect.* Cambridge: Cambridge University Press, 1914.

3 New York: Nervous and Mental Disease Publishing Company, 1921.

zeal for nutrition. We have heard of whole communities, even whole countries, obsessed with an interest in fake cures, but no other group of scientific men has made quite the stir that our nutrition experts have. A few years ago the dentists drew the country's attention to the danger of defective teeth and the benefit to be derived from mouth hygiene and dentistry. The result, as is well known, was a great change in the habits of a large portion of our population and a corresponding improvement in the state of health of those who learned to care for their teeth. In view of the usual lethargy in regard to health habits, it is most gratifying to see the real enthusiasm that has sprung up concerning nutrition.

The reason that any cult becomes popular is because it promises a good deal. Health cults become popular for the same reason—they promise a good deal of good health, presumably, as a general rule, in return for a small expenditure of time, money, and effort. Anything so fundamental as a complete physical examination and a general revision of living habits, even though it promised a good deal, could not become very popular at the present stage of civilization because it involves too much. The cure of malnutrition by feeding is a very simple project. Those who advocate it most warmly are usually those who have in mind an equally simple diagnosis of malnutrition—namely, that based upon a correlation of figures with regard to weight, height, and age, the findings at one time being considered clearly diagnostic in some cases, or more recently, with the more scientific, the figures of one year being compared with those of another. We certainly would not insist that no individuals are "malnourished" because they are underfed, or that weight-height-age figures never indicate "malnutrition". Nor do we say that because "malnutrition" is usually far more complicated a condition than a mere matter of weighing and feeding, it would never be wise to act on a partial diagnosis and correct at least some of the simpler and more obvious lacks. We do maintain, however, that malnourished children and underweight children are not necessarily the same children. We do maintain that the child who is underweight according to the tables is not necessarily malnourished. Dr. Emerson notes these facts in his book, although many of his followers appear to have lost sight of them in attempting to carry out similar plans for nutrition classes. It is not at all scientific to make a diagnosis of malnutrition on measurements, or to attempt to correct it by feeding merely. Yet this is what is being attempted in many cases as a result of a misplaced zeal for the nutrition class. Some charitably inclined individual will order a Fairbanks scale with a measuring rod and a few gallons of milk a day to be sent to the school in her neighborhood. The teacher

is expected, and often tries, to conduct a nutrition class on this basis. The first few chapters of Dr. Emerson's book should be read carefully by any layman who is moved to do anything of this sort. The diagnosis of malnutrition is always a medical matter. The term in itself means nothing unless backed up by a complete physical examination. Least of all does it mean a failure to correspond to the weight tables. If malnutrition were to be diagnosed by laymen, if it were to be the one medical diagnosis that could be safely made by the untrained, it would be far more acceptable to the reviewer to have the basis for this lay diagnosis a mere inspection of the child rather than a mere weighing of him. Probably more teachers and nurses and social workers could arrive at a correct conclusion by looking at the child and comparing him with well children than by weighing him and comparing his weight with the tables.

Dr. Emerson's book will be of very great value to those who are conducting legitimate nutrition classes in which the diagnosis of malnutrition is scientifically made and the treatment of malnutrition is scientifically conducted by all other available means as well as by feeding.

Florence Meredith.

Woman's Medical College of Pennsylvania.

An Essay on the Physiology of Mind. By Francis X. Dercum, M.D., Ph.D. Philadelphia: W. B. Saunders Company, 1922. 150 p.

This essay on the physiology of the mind is clear in thought and word. It goes straight to its mark, which is a physical explanation of mind.

Dr. Dercum joins Dr. Paton in a call for an unemotional study of human behavior and in a conviction that man is not so different from other living things as he prides himself on being, but he centers his attention upon "selective action" as seen in the amœba, the white blood cell, and in the synaptic nervous system. At the synapse, the junction between one neurone and another, chemical or other attraction may result in one neurone's being pulled closer to or farther away from another, thus facilitating or retarding the jump of the nerve impulse. Similar attraction may bring the first neurone at times to a third or fourth instead of a second neurone. Now, whether this result be produced by amœboid motion of the nerve cell or the glia cell or by changing "surfaces of separation", we have a mechanism capable of vast numbers of responses and a physio-chemical explanation of memory, of sleep and dreams, of psychoses, and of consciousness.

Memory depends upon the "facility among the neurones for reforming old combinations". Sleep is the discontinuance of the synaptic approach of axon to dendrite. If in sleep, with its generally widened synapses, a toxin is produced in the blood that facilitates the discharge of nervous impulses across some of the gaps and then impacts are received from the viscera, a field of cortical activity may arise that is protected from the correcting influence of the impulses coming in over the pathways of special sense, and we have dreams. When the synaptic gaps are locally widened, we may find, according to circumstances, a hysterical paralysis of one arm or, what is much the same thing, a system of ideas that cannot be brought into contact with the correcting influence of the impressions continually being received from the outside world. In melancholia, the usual resistance offered by the synapse is increased and in mania it is lessened. In dementia praecox we have relations between neurones which occur so often that the response is fixed and the synapse has lost its ability to respond in more than one way.

And finally, as to consciousness, it is present "only in those responses which are tended by a changing and actively varying relationship among the neurones". "Consciousness is itself a phenomenon of cortical transmission", and the past is represented always by the first and the future by the second neurone. Each impact upon a neurone releases energy that spreads in the line of least resistance of the most frequently traveled paths, but probably always involves some transmission laterally and up and down as well as straight ahead. But consciousness also includes the side and indistinct fields.

An essay dealing with such subjects must be severely held to its main course, and this Dr. Dercum has courageously done. It is both a pleasure and a discipline to follow his argument. He has consistently avoided any discussion either of faith or purpose, but some philosopher who wishes to discuss them may find in this essay a firm foundation of observed facts.

Earl D. Bond.

Pennsylvania Hospital for Mental Disease.

Psychology and Mental Hygiene for Nurses. By Mary B. Eyre, R.N. New York: The Macmillan Company, 1922. 200 p.

This little volume has at least the virtue of brevity, and an astonishing amount of material is covered. The style is simple and terse, almost definitional; paragraphs are short and headlined; there is a summary for each chapter.

The first half of the book gives a primer outline of general psychology according to the old-fashioned "faculty" conception. Forced

and often unwarranted attempts are made to establish an organic basis for mental activity. The second half begins with a more general philosophical discussion, sketchy in character, of the forces operative in the human personality. There follows an epitome of the more common neurological conditions and psychoneurotic reactions, the latter dealt with purely on the descriptive level. Child psychology is given superficial consideration. A chapter deals with the Binet-Simon intelligence tests. Throughout the work practical lessons are drawn for the nurse in regard to her own and her patients' mental attitudes.

Modern dynamic psychology of the Freudian type is touched upon daintily from time to time, but in a way to give no more than verbal orientation to the novitiate. A striking defect is the omission of any bibliography to guide the reader who may wish to pursue further some of the subjects considered in the text.

The book was evidently written for those with little background for the development of psychological knowledge. As a source from which to cram for a formal examination for nurses it is quite ideal. It falls far short of filling the real need for something that shall put the nurse in touch with modern points of view on human behavior and psychopathology.

Martin W. Peck.

Boston Psychopathic Hospital.

Whittier Social Case History Manual. By J. Harold Williams, Willis W. Clark, Mildred S. Covert, and Edythe K. Bryant. Whittier: California Bureau of Juvenile Research (Bulletin No. 10), 1921. 98 p.

The purpose of this volume, one of a series issued at the California State School for Boys, is given in the introductory note, in which we are told that the aim is to describe the methods used in the Bureau of Juvenile Research, that the monograph may serve as a guide in the training courses for its own social workers and also as a means of informing others of the work carried on by the bureau. It is primarily, as its title indicates, a manual, comprehensive in scope and offering, besides, a bibliography, so that the interested reader may study further along any of the numerous lines that touch upon social case-work. The method outlined is more applicable for institutions and, it would seem, could be carried out only where there is either a very large staff or where the number of individuals studied is comparatively small.

Directions for the more mechanical aspects of the work—such as

recording, use of charts, order of arrangements, and the like—are very specific. This can hardly be said of the sections on such topics as family history, which, although they give information gathered concerning even remotely distant relatives, offer very little definite suggestion as to the specific qualities for which one is to inquire.

It is evident that the work of this research bureau is exceedingly thorough. Many sources are canvassed and a vast amount of data is gathered. To the reviewer it does not seem altogether clear that, once gathered, this data is focused upon the problem of delinquency. Much of it, surely, is not relevant in relation to the actual problem that the individual presents, although it should furnish ultimately remarkably fine material for scientific investigation of subjects biological, psychological, and sociological. It is stated that the goal is to answer the question: What should be done for the propositus? But one hardly sees the relationship of many of the facts to this question; nor do there seem to be always specific recommendations for the treatment of the individual, if we may judge from the case studies cited.

The illustrative case histories included show clearly the industry and thoroughness of the staff. It is not often that facts are obtained concerning five generations and ninety-seven individuals, all to answer the problem of one defective lad. It seems altogether too bad that out of this case material so little should bear upon the problem of delinquency *per se*.

In the light of the intensive study of the individual from so many sources, the final discussion of the case is altogether inadequate and one might readily take issue with the interpretations made, especially concerning "the probable cause of delinquency". In no one of the three cases given did the reviewer agree.

But whatever one may feel about the details, many of which are after all only incidental to the problem of the volume as a whole, commendation and admiration are once more due to the progressive spirit of the Whittier State School and the laudable desire of the research department to standardize its work and perfect its methods.

Augusta F. Bronner.

Judge Baker Foundation.

The Healthy Child from Two to Seven. By Francis Hamilton Macearthy, M.D. New York: The Macmillan Company, 1922. 235 p.

A book from this firm, with this title, would be likely to attract some attention, especially at a time when the conservation of a normal state of health is becoming more interesting than the correction of

the results of disease. An adequate book on this subject is much needed. Whether or not the parent who desires to do the best for his child will find quite all that he needs in this book, he will surely admire Dr. Maccarthy's ideals. "A city", he says, "is no place for real living. Rents are so high that only large incomes can command an apartment or a house worthy to be called a home." This statement near the beginning of the book would be likely to cause a necessarily urban parent to lose interest at once. "In the country there is space, less confusion, and greater safety. Less supervision is needed where are large yards, fields, and trees." It is hardly possible to disagree with the writer at such points. We agree with him when he says, "Now if ever is the time for life in God's out of doors, plenty of wholesome food, careful training, and long nights of refreshing sleep." We would agree with him also if he had merely said that healthful conditions and good care are what the child needs from two to seven, but we would hardly have felt that the reiteration of such truisms would constitute scientific grounds for a book for anxious parents.

It is plain that Dr. Maccarthy is a parent. He speaks with considerable affect in places. "There is no doubt that mothers and fathers sacrifice much for their children, and because of the little folks in their own home, feel tenderly toward all children." This tenderness, he goes on to say, in a not very original manner, is not enough. "As parents, we must not only adore our children; we must love them wisely." A general tone of adoring parenthood and happy home life pervades the book. "Given a homelike living room in which is a good-sized fireplace, what wonderful possibilities it holds for family gatherings in front of its friendly light and warmth! What a jolly place it is for the telling of bedtime stories, for popping corn and family counsel!" The chapters on training and education and on nerves and the mind would be of value in a distinctly elementary way if any parents could be found to whom the information and suggestions contained in them were not already an old story. Undoubtedly Dr. Maccarthy has found that there are parents in whom it is not safe to take anything whatever for granted.

Florence Meredith.

Woman's Medical College of Pennsylvania.

Penology in the United States. By Louis N. Robinson, Ph.D. Philadelphia: The John C. Winston Company, 1921. 344 p.

This work may be considered a concise and excellent history and review of most of the material published prior to 1920. It gives a systematic presentation of the many phases of the subject, and for

this reason is of value to the student or one entirely ignorant of the methods employed in the treatment of the offender. Fortunately, it is entirely devoid of sentimental twaddle.

The author concedes that we have not solved the criminal problem and that we know very little about criminals. He suggests that it may be well to place correctional institutions under the management, or at least under the supervision, of the educational department of the state. He wisely accepts the rapidly spreading idea that we must cease to consider our penal institutions merely as places of detention, but must go further and develop them as laboratories for the individual study, treatment, and training of the prisoner.

Very interesting is his presentation of the controversy between the advocates of the Pennsylvania plan and the so-called Auburn plan. Although this controversy took place many years ago, it still has definite relation to present-day problems in the administration of our penal institutions.

On the subjects of probation and parole, the author is well qualified to speak since he has been actively identified with those phases of the work for many years. It is stated that in 1920 one hundred thousand offenders were placed on probation, and that there were during that period only two thousand probation officers under appointment. This deplorable lack of probation officers—and the same thing is practically true as it relates to parole work—prevents the functioning of the system to anything like the maximum of its potentialities.

Considerable space is given to a discussion of the extremely important subject of prison labor. It is evident that the author has given careful thought to the subject, and while his conclusions may not be to the satisfaction of all those directly or indirectly acquainted with the difficulties involved, it must be admitted that his round-up of the various phases of the problem is of value.

With regard to capital punishment, he presents with fairness the arguments for and against, but his final conclusion indicates that he is decidedly averse to the use of the death penalty.

In the closing chapter his enumeration of next steps is to be commended. These include the socialization of our criminal courts, the further development of probation, the establishment of institutions for special types of offenders, the elimination of county and municipal jails as places of detention for sentenced prisoners, the abolition of the death penalty, the facilitation of transfer from one institution to another, and the making the development of character the goal of prison administration.

E. R. Cass.

American Prison Association.

THE EMOTIONS. By Carl Georg Lange and William James. Psychology Classics Reprint, edited by Knight Dunlap. Baltimore: Williams and Wilkins Company, 1922. 135 p.

A very happy choice was made by the editors of the new Psychology Classics series when they selected for their first volume the original articles by James and Lange on the emotions. Until now the original article by James, which startled the complacent philosophical psychologists and which pointed the way for recent investigations, lay buried in one of the volumes of *Mind*, published in 1884.

Although the fires of the original controversy have for the most part died down, the fruits of the victory are coming to light more and more every day. There has been, perhaps, no issue more decisive in permanently breaking psychology away from the apron strings of philosophy than the physiological and behavioristic interpretation of the emotions as against the philosophical theories of the "affections of the soul". Since the publication of Darwin's *Expression of Emotions in Man and Animals*, the progress toward scientific and experimental treatment of the emotions has been rapid. Darwin was particularly interested in the facial expression during emotions of various kinds, and the outward similarity of emotional expressions with those of extreme fatigue and exhaustion. Philosophy was still closely bound up with science, however, for we find him giving a teleological explanation as the cause of the various outward manifestations of the emotions. James is not so interested in explaining as in describing, and proceeds further than Darwin by making more extensive observations—the emphasis shifts from the description of the voluntary striated musculature that is involved to the involuntary and visceral system. He hints at a great complexity and "subtlety". "Hardly a sensation comes to us without sending waves of alternate constriction and dilatation down the arteries of our arms. The blood vessels of the abdomen act reciprocally with those of the more outward parts. The bladder and bowels, the glands of the mouth, throat, and skin, and the liver, are known to be affected gravely in certain severe emotions, and are unquestionably affected transiently when the emotions are of a lighter sort" (page 15). Here is an anticipation of the work done by Cannon and others.

Throughout the article, which is written in the usual delightful James style, one feels the verve of the propagandist who knows that he has much opinion against him and that his statements will be considered radical. It is this that makes the article alive and full of interest to us to-day. When we unsuspectingly come upon this well-known sentence: "If we fancy some strong emotion and try to

abstract from our consciousness of it all feelings of its characteristic bodily symptoms, we find we have nothing left behind, no 'mind-stuff' out of which the emotion can be constituted, and that a cold and neutral state of intellectual perception is all that remains", we recognize it as a sword, even though now it has been turned into a plowshare.

It is interesting to note that in making practical application to everyday life from his theory, James arrives at a set of rules quite different from some of the more modern psychologists. If an emotion is repressed, it will disappear, according to James—"when we teach children to repress their emotions, it is not that they may *feel* more—quite the reverse. It is that they may *think* more, for to a certain extent whatever nerve currents are diverted from the regions below must swell the activity of the thought tracts of the brain." Perhaps here is a chance for another controversy!

In publishing the article by Carl Georg Lange, the editors have performed a double service, for they have given us the first English translation of the original article by Lange, and have placed it alongside of the James article for comparison. Although the theory has frequently been called the "James-Lang theory", each author developed his theory independently, nor are they identical. Lange speaks of the "involuntary physical manifestations which go hand in hand with the subjective feelings of fear, joy, etc." James does not differentiate, but calls these bodily manifestations the emotions themselves. Lange, however, gives a much more detailed analysis of the emotions, describing the four principal emotions—sorrow, joy, fright, and anger—in physiological terms, fright being accompanied "by paralysis of voluntary musculature and a kind of convulsive condition of the vascular musculature". He suggests that the best method of studying the emotions is the observation of animals and infants—methods that have been used by some of our contemporary psychologists. Like James, Lange was convinced that the notion of the emotions popular at that time was a putting of the cart before the horse, and that in discussing the "influence of the affections upon the body", Aristotle was looking at the problem from the reverse side. Lange practically reduced all the causes of emotional disturbances to disturbances in vasomotor innervation. The article is distinctly modern in tone and the translation by Miss Istar A. Haupt brings out the argument very clearly.

The third article is a reprint from James' *Principles of Psychology*, Chapter XXV—the well-known chapter on emotions. Here the style is more controversial than in the first article. James reviews Lange's

contribution, takes issue with him on various points, and answers the objections that were raised to his own theory after its original publication in *Mind*.

It is certainly very convenient to have these three papers reprinted and bound together in a small, easily handled volume. It will be welcomed especially by those who are teaching psychology, for it will save time and serve as a ready reference book.

Sadie Myers Shellow.

Smith College.

A Psychiatric Milestone. Bloomingdale Hospital Centenary, 1821–1921. Printed privately by the Society of the New York Hospital, 1921. 220 p.

On May 26, 1921, the Bloomingdale Hospital celebrated its centenary. The principal place in the celebration was given to the sociologic and medical aspects of the work of the hospital, with special reference to the progress that had been made in the direction of the practical usefulness of psychiatry in the treatment of illness generally and in the management of problems of human behavior and welfare. In this beautifully printed volume, the governors of the New York Hospital have preserved the valuable addresses that were made on that occasion—*An Historical Review*, by Edward W. Sheldon, President of the Society of the New York Hospital; *The Contributions of Psychiatry to the Understanding of Life Problems*, Dr. Adolf Meyer; *The Importance of Psychiatry in General Medicine*, Dr. Lewellys F. Barker; *The Biological Significance of Mental Illness*, Dr. Richard G. Rows, Director of the Section on Mental Illnesses of the Special Neurological Hospital, Tooting, London, England; *The Relation of the Neuroses to the Psychoses*, Dr. Pierre Janet, Professor of Psychology, College de France; *The Medical Development of the Bloomingdale Hospital*, Dr. William F. Russell.

In the appendices have been preserved a number of historical documents of importance, including a letter on pauper lunatic asylums from Samuel Tuke to Thomas Eddy, 1815, and Thomas Eddy's communication to the Board of Governors, April, 1815. It was this communication that led eventually to the establishment of Bloomingdale Hospital in 1821 on the site now occupied by the library of Columbia University. The hospital was moved to its present location in White Plains in 1892, and the original site is now occupied by Columbia University, Barnard College, the Cathedral of St. John the Divine, St. Luke's Hospital, the Women's Hospital, and The National Academy of Design.

Valuable photographs have likewise been preserved in the volume—New York Hospital and Lunatic Asylum, 1808; Bloomingdale Asylum, 1821, 1894, 1921; the tableau pageant given at the centenary; and an autograph photograph of Thomas Eddy.

THE SOCIETY OF THE NEW YORK HOSPITAL, 1771–1921. COMMEMORATIVE EXERCISES, 150TH ANNIVERSARY. Privately printed, 1921. 96 p.

A beautifully printed record of the addresses made at the exercises held in Trinity Church, New York City, October 26, 1921, to commemorate the 150th anniversary of the granting of a charter to the New York Hospital. The more significant addresses are by Edward W. Sheldon, President of the Society of the New York Hospital; Nathan L. Miller, Governor of the State of New York; and the Honorable Elihu Root. Mr. Sheldon's address is a valuable historical sketch of the work of the hospital and of the early medical activities in New York City.

Governor Miller stresses the importance of the work being done at the Bloomingdale Hospital (the department of the New York Hospital devoted to the treatment of nervous and mental diseases) particularly in the demonstration of the value of occupational therapy. He feels that the state should profit by this experience and that more intensive work along this line should be undertaken by the state hospitals. Mr. Root points out that in this country we "depend upon individual enterprise for our motive power" rather than upon the government, and characterizes the hospital as an example of the "free and independent enterprise of our people". With feeling he calls attention to how lives are built into institutions: "The men who originated and have maintained the New York Hospital have had civic pride and the most generous of hearts. I myself have known in close friendship many of the men who were long ago giving their time and their labor and their enthusiasm and their loyalty to this institution. There are but few, I fear, who remember them now; but it seems to me that in this celebration that I am taking part in, I am saying something in honor of Cornelius Bliss and Lewis Stimson, and the others who gave so much of their lives in this work. Their names will not be long remembered; their predecessors' names are already forgotten. But what matters that? They have built their lives into this institution. Their spirits live in the spirit of this institution, and make it always strong, wholesome, and effective. Theirs is no human fame that endures for very long. What if their names are forgotten? They are here, they live here, their influence continues here, and the things that they have

done still live in this institution, and in a few other institutions of a similar spirit."

Several photographs of historic interest are included in the volume, among them a view of the New York Hospital, 1808; the approach to the hospital, 1851; and Bloomingdale Asylum in 1881, New York City (the site of the present Columbia University Library).

SELF-MASTERY THROUGH CONSCIOUS AUTO-SUGGESTION. By Émile Coué. New York: American Library Service, 1922. 93 p.

This book has been advertised so extensively that it is probably well to say something about it, although ordinarily it would receive no space. So far as auto-suggestion and the views of Coué are concerned, they need not be discussed in connection with this book as they have already been discussed in MENTAL HYGIENE in a review of Baudouin's *Suggestion and Auto-suggestion.*[1] It is necessary only to point out the type of book this particular book is; comment is superfluous.

The book is a fair-sized paper-covered pamphlet of ninety-three small pages (approximately one-half the size of the MENTAL HYGIENE page cut horizontally), badly printed on inexpensive paper. It is advertised to sell for one dollar ("postpaid, bound in genuine flexible leather, $1.75"). It is not written by Coué, as one is led to believe. An article occupying the first thirty of the ninety-three pages is signed by him; the last five, on *Education As It Ought To Be*—in which he says, "in sober truth, if a woman, a few weeks after conception, make a mental picture of the sex of the child . . . of the physical and moral qualities . . . the child will have the sex and qualities desired"—are also by him. Six pages are devoted to *Thoughts,* etc., by Coué, although the last two pages are by others—such as *Suggestion Sustained by Faith Is a Formidable Thing,* signed "Docteur A. L., Paris (July, 1920)"—and seven pages to *Observations*—brief statements to the effect that "T— Maurice, aged 8 and and a half" has been cured of a club foot and Mme. M— and Mme. D— of prolapse of the uterus, and the like.

Seventeen of the ninety-three pages are devoted to testimonial letters of the old patent-medicine type and five more pages to a *Homage.* The remaining pages of the pamphlet are given to odds and ends of a like character. A form of application for membership in the "Lorraine Society of Applied Psychology—Suggestion, Auto-suggestion, Hypnotism" concludes the book except for the precepts on how to use auto-suggestion on the inside of the front cover. As has been said, the price asked for this book is one dollar.

[1] October, 1921, Vol. 5, pp. 856–7.

THE DEPTHS OF THE SOUL: PSYCHOANALYTICAL STUDIES. By William Stekel. Translated by S. A. Tannenbaum. New York: Moffat, Yard, and Company, 1922. 216 p.

Stekel has written books that are to be read (his *Bisexual Love,* for example), but this is not one of them. To the book he has given an absurdly pretentious title, but to the text—short discourses on obviously popular themes, *Jealousy, Gratitude, Independence, Moody People,* etc.—he has given little but aphorisms and an attempt at a literary *flair.* The depths of the soul are not to be sounded or knowledge of importance disseminated in superficial books such as this.

THE PSYCHIC HEALTH OF JESUS. By Walter E. Bundy, Ph.D. New York: The Macmillan Company, 1922. 299 p.

A careful and critical review of the work of those who—from Strauss and Renan to Binet-Sanglé—have pronounced Jesus of unsound mind. Chapters are also given to a discussion of source material and of the personality of Jesus from the pathographic point of view. The author points out that psychiatric diagnoses cannot safely be based on biographical or autobiographical material alone and that in the case of Jesus the material is entirely inadequate. He concludes that Jesus was not an ecstatic (Holtzmann), an epileptic (Rasmussen), or a paranoiac (De Loosten, Hirsch, Binet-Sanglé) and that although "his picture of the future, and that of many of his contemporaries, was fantastic and fanciful, it was not fanatical". The term psychoanalysis is used frequently throughout the book, but evidently in its etymological and not in the technical sense. There is an excellent bibliography. The author is Associate Professor of the English Bible at DePauw University.

THE TECHNIQUE OF PSYCHOANALYSIS. By David Forsyth, M.D., D.Sc., F.R.C.P. New York: Moffat, Yard, and Company, 1922. 133 p.

The technique of psychoanalysis cannot be taught in a small book. However, presupposing a considerable knowledge of the subject on the part of the reader, as the author does, the book will be found helpful by physicians undertaking the study of psychoanalysis. The major portion of it is given to a discussion of the analysis proper, but there is an important chapter on the analyst himself and one on the prerequisites of treatment.

NOTES AND COMMENTS

Illinois

A new building has been opened at the Elgin State Hospital to be devoted exclusively to ex-service men. The construction of this building was begun in June, 1921, and it was completed the following May. It is a one-story building comprising three distinct units. It contains a dining-room that seats 175 persons. It has two main wards and four smaller wards.

Kentucky

The Kentucky Child Welfare Commission has been created by Chapter 107, Laws of 1922. This commission is to be composed of nine members appointed by the governor, three for a period of one year, three for two years, and three for three years. It shall be the duty of the commission to continue the survey of child welfare begun by the children's code commission authorized in 1920, to study the needs of Kentucky children, to present to the governor and legislature prior to each session a report of their findings and recommendations, and to be ready at all times to advise the governor or any member of the legislature concerning the bills relating to children that may be introduced at any session.

Louisiana

The State Colony and Training School received from the 1922 legislature an appropriation of $266,000 for the next biennial period. Of this amount, $155,000 is to be expended for new buildings and $25,000 for a power and heating plant. This institution was authorized by the 1918 legislature as a state institution for the feebleminded and was opened in December, 1921.

The law relating to admission to the State Colony and Training School has been amended by Act 27, Laws of 1922. The new law allows admission to this institution without court procedure, in accordance with the following section: "On application for admission to a hospital made on behalf of a person who is a resident of the state, the superintendent and board of administrators may admit him to the same, although he had never been adjudged feebleminded. Upon receipt of the application, the superintendent must forward to the physicians proper blank forms to be filled out, giving the history of the patient and such other information as may be required. The

admission, discharge, and parole of such voluntary admission are left to the discretion of the board of administrators."

The name of the state hospital for mental diseases located at Jackson has been changed by legislative enactment from "The East Louisiana Hospital for the Insane" to "The East Louisiana State Hospital".

Massachusetts

A new parole law for mental defectives was enacted by the 1922 legislature. It permits the trustees of any state school for the feebleminded to allow any inmate to leave the institution on parole for such length of time and under such conditions as they may determine. The length of time may be extended and the conditions changed from time to time. Before granting a parole to any person, the trustees must have an investigation made of the home and other conditions that may affect his welfare, and must provide such supervision as they deem necessary. The trustees have power to revoke the permit and to return the patient to the school.

Missouri

Work is starting on a new building at State Hospital No. 2 at St. Joseph. The building will be devoted to surgery, with operating, dental, X-ray, and laboratory rooms. It will accommodate 42 patients and cost about $100,000.

New Jersey

Chapter 101, Laws of 1922, provides for the commitment to the house of detention for criminal insane at the State Hospital at Trenton of persons who have been sentenced to death and are found to be insane. When such a person is sufficiently improved to understand that he has committed the crime for which he was convicted, is aware that he is amenable to punishment therefor, and is appreciative of his situation as one condemned to death, he shall be returned to the state prison and subsequently resentenced. When any person shall have escaped indictment or have been acquitted upon the ground of insanity, he shall be committed to the State Hospital at Trenton until his reason is restored, but such person shall not be released except upon order of the trial justice having jurisdiction to try such person.

New York

A new mental-hygiene clinic has been established in Batavia by the Rochester State Hospital.

Mrs. Eleanor Clarke Slagle has been appointed by the state hospital commission director of occupational therapy in the state hospitals.

The following new buildings for the Utica State Hospital have been authorized: a nurses' home, a dormitory for 300 patients, and a building to accommodate 125 working patients.

Rhode Island

A law enacted by the 1922 legislature allows the transfer of patients who have been committed to the state hospital for mental diseases or Butler Hospital to a hospital under the control of the United States Government, whenever it shall be deemed by the superintendent of either of the former hospitals to be for the welfare of the patient to be thus transferred.

Chapter 2230, Laws of 1922, which is in amendment of and in addition to a law enacted in 1917 creating the penal and charitable commission, provides for a director of state institutions as the chief executive officer of the commission. One provision of the new law is of especial interest in that it authorizes the commission to appoint a resident physician and two assistant physicians for the institutions under its control at Cranston, one of whom must be a psychiatrist. The institutions thus affected are the state prison, the state workhouse and house of correction, the state school for boys, the state school for girls, and the state infirmary.

South Carolina

A law passed by the 1922 legislature states that the regular discharge of a patient from the state hospital for mental diseases shall restore to him his legal status as to property and contractual rights, provided that any patient of that hospital duly adjudged insane in any probate county of the state obtain from the superintendent of the state hospital a certificate showing that the patient has been adjudged sane by the medical staff of the hospital.

Virginia

A law enacted by the 1922 legislature authorizes that occupational therapy, with part-time or full-time services of one or more occupational aids, be provided in institutions caring for children who are either physically or mentally disabled.

A 1922 amendment to the law relating to the adoption of minor children authorizes the court, upon the filing of the petition, to direct a probation officer or other officer of the court, or an agent of the state or county or city board of welfare, or some other discreet and competent person, to make a thorough investigation, directing his

inquiry along the following lines: (1) why the parents, if living, wish to be relieved of the care of the child; (2) whether they have abandoned the child or are morally unfit to have its custody; (3) whether the proposed foster parent or parents is or are financially able and morally fit to have the care of the child; and (4) the physical and mental condition of the child. For this latter purpose the investigator may secure the opinion of a reputable physician or competent mental examiner.

The board of charities and corrections is to be continued under the name of state board of public welfare in accordance with Chapter 105, Laws of 1922. The board is to appoint a commissioner of public welfare as its executive officer, and it may also appoint an assistant commissioner of public welfare. All other assistants and employees attached to the board are to be appointed by the commissioner. The members of the board, five in number, are to be appointed by the governor, subject to confirmation by the senate. The duties of the new board are practically the same as those of the former board, but the following new provision is worthy of special mention:

"The board is hereby authorized and empowered to create a children's bureau, and if such bureau be created, the commissioner of public welfare may, subject to the approval of the board, appoint a director of the bureau and such assistants as may be necessary. The children's bureau, subject to the control of the board, shall have general supervision of the interests and welfare of the mentally defective, dependent, delinquent, and neglected children of Virginia; shall investigate conditions bearing upon this subject, and shall from time to time recommend to the board of public welfare and to public and private agencies, measures, curative and remedial and preventive or constructive, for the improvement of conditions and the better safeguarding the welfare of the children of the state. The board is hereby authorized and empowered to receive mentally defective, delinquent, dependent, and neglected children committed to it by courts or justices, and all children declared by any court or justice to be delinquent and not suitable for probation shall be committed to the state board of public welfare, which board is authorized to establish one or more receiving homes for the care, supervision, and study of mentally defective, delinquent, dependent, or neglected children thus committed to it, or to make arrangements with satisfactory persons, institutions, or agencies, or with cities maintaining places of detention for children, for the temporary care of its wards. The board is further authorized to make a careful physical and mental examination of every such child, to investigate in detail the personal and family history of the child and its environment, and to place children in approved family homes, in suitable licensed institutions, all within the state of Virginia, unless by written consent of its parent or guardian, with suitable licensed agencies, or in state institutions. Children committed to state institutions dealing exclusively with children, by the board, shall take precedence as to admission over all others and shall in all cases be received into the said state institution as soon as possible. Children placed in family homes or institutions may be transferred for reasons deemed sufficient by the board."

An examination for venereal disease is required by Chapter 315, Laws of 1922, of all persons admitted to the state penitentiary, state penitentiary farm, any branch prison, any reformatory, any hospital for insane or colony for epileptic and feebleminded. Any such person found to have a venereal disease must be treated and, if possible, cured.

When a dependent, neglected, or delinquent child is brought before a court in the state, the court may either before or after the hearing cause the child to be given a physical and mental examination by a competent physician or physicians or an approved mental examiner. If it shall appear to the court that the child is mentally defective, he must be examined by two licensed physicians or approved mental examiners, and upon their written statement that the child is mentally defective, the court may commit the child to an institution for mentally defective children. Parents, guardians, and custodians must be given due notice of the proceedings. When the health or physical condition of a child requires it, the court may cause the child to be treated by a competent physician or placed in a public hospital or institution for treatment. These provisions are included in Chapter 481, Laws of 1922, of Virginia.

Mental Hygiene Survey of Cincinnati

The Mental Hygiene Council of the Public Health Federation of Cincinnati has issued in pamphlet form a short summary of the report on the survey of Hamilton County, Ohio, conducted by The National Committee for Mental Hygiene, at the request of the Mental Hygiene Council, during the year 1921–22. The survey was directed by Dr. V. V. Anderson of the National Committee. Its aim was to determine the part played by abnormal mental conditions—feeblemindedness, psychopathic states, epilepsy, and the like—in the various social problems of the city and county, particularly dependency, chronic unemployment, illegitimacy, family desertion, vagrancy, juvenile delinquency, and adult crime, and to ascertain the frequency of mental abnormalities among the public-school children. The material investigated included the "run of the mine" of the cases under the care of the Ohio Humane Society, the Associated Charities, and the Bureau of Catholic Charities, fifty dependent families under the care of the United Jewish Social Agencies, the "run of the mine" of the juvenile court, the opportunity farms for boys and girls, the Hamilton County Jail, the city and county infirmaries, the Home for the Friendless, the Catherine Booth Home, the boarding-homes children, and finally about 5,000 public-school children. The object was to secure a thorough-going physical, mental, and social diagnosis of each

individual studied. Both psychiatric and psychological methods were used in the mental examination, which was directed, first, to determining the presence or absence of mental disease in the individual in question; second, to evaluating his intelligence; and third, to estimating his character and personality make-up. The social investigation included a study of home conditions in all cases except those of public-school children who were not found to be suffering from any abnormal mental condition.

The findings of the survey, as summarized in the pamphlet, are as follows:

Delinquency

Approximately two-thirds of the children studied at the juvenile court were found to be suffering from some form of mental abnormality—either psychopathic personality, epilepsy, feeblemindedness, border-line mental defect, mental disease, or subnormal intelligence. Nearly two-thirds of these children had intelligence quotients of over 80, which shows that marked inferiority in intelligence is not an outstanding causative factor in their delinquent conduct, but that the problem is primarily one of behavior difficulties or mental maladjustments. Approximately 7 out of every 10 children came from homes in which conditions in the way of parental control and parental supervision were at the lowest ebb, the homes of the girls being more unfavorable than those of the boys; 9 out of every 10 delinquent girls came from homes that received the lowest possible rating in respect to parental control and supervision. Twenty per cent of the mothers in the group of delinquent girls were sex delinquents. Forty per cent of the fathers of the psychopathic delinquent children were alcoholic, and 25 per cent were guilty of nonsupport or of desertion. Some idea of the cost of these socially maladjusted families can be gathered from the fact that 3 out of every 5 of them have come into contact with one or more of the social agencies of the city, in addition to the juvenile court.

Only 13 per cent of the girls at the Girls' Opportunity Farm were diagnosed as normal; 40 per cent were suffering from psychopathic personality, and 21 per cent from border-line mental defect or feeblemindedness. Of 68 boys examined at the Boys' Opportunity Farm, only 11 were found to be normal; 30 were suffering either from border-line mental defect or feeblemindedness, and 15 were diagnosed as psychopathic personality.

Of 100 cases, the "run of the mine", studied at the Ohio Humane Society, 66 per cent were suffering from some nervous or mental abnormality; 26 per cent were feebleminded, and 8 per cent mentally diseased.

Of 200 cases studied at the Hamilton County Jail, 74.5 per cent were classified as cases of mental disease, mental defect, psychopathic personality, epilepsy, psychoneurosis, or subnormal intelligence.

Of a group of 70 unmarried mothers, only 20 were classed as normal. There were 28 cases of border-line mental defect or feeblemindedness, 10 of subnormal intelligence, 7 of psychopathic personality, 3 of psychoneurosis, and 2 of epilepsy.

Fifty-one per cent of the adult delinquents were repeated offenders.

Dependency

Twelve hundred cases of dependency were studied.

In contrast to the group of delinquent children, of whom approximately two-thirds were suffering from some nervous or mental abnormality, it is noteworthy that more than two-thirds of the group of dependent children were classified as normal. The majority of the adult dependents, on the other hand, were mentally or physically sick or handicapped.

Of 61 adult dependents studied at the Bureau of Catholic Charities, 4 out of every 5 were found to be suffering from some abnormal mental condition.

Of 212 cases studied at the United Jewish Social Agencies, as part of a survey of 50 dependent Jewish families, 50 per cent were suffering either from mental disease, feeblemindedness, epilepsy, psychopathic personality, or endocrine disorders.

Of 122 relief cases, the "run of the mine", at the Associated Charities, approximately 72 per cent were classified as mentally abnormal.

Of a group of cases of chronic unemployment studied at the Associated Charities, 71 per cent were suffering either from endocrine disorders, epilepsy, mental deficiency, mental disease, or psychopathic personality, or were distinctly subnormal in intelligence.

Of 394 patients at the city infirmary, only 20.3 per cent of the whites were mentally normal; all the rest were either mentally sick or mentally crippled. Of the 39 negroes studied at this institution, only 3 were diagnosed as normal.

Of 162 cases at the Hamilton County Home, only 4.5 per cent of the white persons could be classed as mentally normal. All the negroes were either feebleminded or mentally diseased.

The Public Schools

The public-school children studied were the pupils of five typical schools in different parts of the city. The aim was to get a fair picture of the average child and to ascertain what proportion of the children were mentally handicapped or maladjusted.

It was found that 2 per cent of the children studied were feeble-minded; 2 per cent were cases of border-line mental defect; 3.5 per cent were diagnosed as nervous or psychopathic and 4.8 per cent as subnormal; 0.2 per cent were suffering from epilepsy and 0.7 per cent from endocrine disorders. It should be noted that the children suffering from the more gross mental defects had already been weeded out and placed in special classes by the public-school authorities, and were therefore not included in these percentages.

Approximately 6 per cent of the children studied showed marked conduct disorders. A great majority of these conduct cases were among the children suffering from mental handicaps.

The survey showed that the public schools of Cincinnati are particularly well equipped to deal with the problem of school children whose shortcomings are largely in the field of general intelligence, learning capacity, vocational aptitudes, and the like, but that the psychopathic children and the children with conduct disorders, who form such a large percentage of the city's public-school problems, are not being effectively dealt with; the conditions from which they suffer are not adequately recognized and given the medical and social treatment that they deserve.

Conclusions

The outstanding facts revealed by the survey are (1) the vital part played by psychiatric conditions in all the social problems the city has to meet and (2) the inadequacy of the facilities for dealing with these conditions. While splendid efforts are being made in various directions to meet the mental-hygiene needs of the city, in no place is the work sufficiently comprehensive or adequately enough financed to supply the service that the situation demands. Various organizations are doing excellent clinical work, but each piece of work is a separate unit, revolving on its own axis, absolutely independent of other activities. The urgent need is for a large central psychiatric clinic which would coördinate all the work of this kind that is being done in the city, serving the social agencies, the institutions for delinquents and dependents, the juvenile and adult courts, the public schools, and the community in general.

Emphasis is laid upon the fact that this central clinic should not be merely a classification clinic. It should be primarily a treatment clinic, which, through its social-service department, would coöperate with the trained workers of the city's social agencies, with the probation officers in the courts, and with the supervisors of the problem school children, to work out a program for the treatment of each individual brought to it for study.

The clinic should be a part of the clinical facilities of the General Hospital. Its director should be a full-time man, a physician with ample clinical experience who has specialized in psychiatry, with particular reference to the social phases of the problem. In addition to directing the clinic, he should be Professor of Social Psychiatry and Mental Hygiene at the University of Cincinnati, and give courses of lectures in the medical school and the law school and in connection with the training of school teachers and social workers.

A complete report of the survey, including a study of the feeble-minded in Hamilton County and a state program for mental hygiene, can be obtained from the Public Health Federation of Cincinnati, 25 East Ninth Street, Cincinnati, at the price of a dollar.

Mental Hygiene Activities in Pennsylvania

Recognizing the importance of occupational therapy in hospitals for mental disease, the Bureau of Mental Health of the Pennsylvania Department of Public Welfare, which went into operation last December under the directorship of Dr. William C. Sandy, has established the position of field representative in occupational therapy and appointed to the position Miss Mary L. Putnam, who has had extensive experience in the work in various states and institutions. Miss Putnam is now making a survey of occupational-therapy activities in the institutions of Pennsylvania and is also available for consultation. Several of the mental hospitals in Pennsylvania are doing excellent work in occupational therapy, and it is hoped that, through Miss Putnam's efforts, this work will be extended throughout the entire state.

In the interest of extramural activities, the department of public welfare has appointed Miss Florentine Hackbusch to the position of field representative of the bureau of mental health. Miss Hackbusch, who was formerly field agent of the New York State Commission for Mental Defectives, will assist in organizing and conducting mental-health clinics. The bureau is promoting the establishment of such clinics and expects in the near future to have one in operation in every section of the state.

Finding that there were several hundred beds available in the state hospitals, the bureau has revoked the licenses of a number of small county hospitals for mental disease and transferred their patients to the state hospitals. This has been done in five counties and similar arrangements are being made in three others.

The Danville State Hospital, as a part of its community-service activities, has instituted a course of lectures on abnormal psychology and mental hygiene at the state normal school at Bloomsburg.

Lectures were delivered to 140 senior students during the winter months, and the summer course was attended by 550 teachers, representing communities in all parts of the state. The lectures are supplemented by clinical demonstrations at the hospital.

Probably Manic-Depressive

Under the heading *Osteopathic Research,* the *Journal of the American Medical Association* quotes the following from the Dayton (Ohio) *Herald:*

"Dr. Burns, who is head of the A. T. Still Research Institute, spoke Tuesday night at a meeting of the Dayton District Osteopathic Society.

" 'We use three or four hundred rabbits, monkeys, guinea pigs, and similar animals each year', she said, Tuesday. 'We produce certain lesions, study their effects, and then either reduce the lesion or kill the animal as seems best for the purpose of the experiment. We are careful to cause the animal no pain.

" 'We were able to render one rabbit blind, by a lesion similar to the celebrated case of Tom Skaybill, whose sight was restored by one of our practitioners. We were unable to restore the rabbit's sight however, as it died of indigestion.

" 'We caused one rabbit to develop dementia praecox and held it under observation for three years. It lost all interest in life, ate very little, grew dirty and unkempt, and was generally worthless. We are now making the adjustment required and the rabbit is beginning to recover.

" 'As a result of our work, we have been able to discover causes of several ailments now marked "cause unknown" in standard medical works. Among them are certain forms of localized dropsy and paralysis.' "

Neuropsychiatric Number of the New York Medical Journal

The *New York Medical Journal and Medical Record* for September 6 was devoted to the subject of neuropsychiatry. Sir Frederick Mott, of London, and Dr. Miguel Prados Y Such, of Madrid, were the coauthors of the leading article, *Further Pathological Studies in Dementia Praecox, Especially in Relation to the Interstitial Cells of Leydig.* This paper, which was concluded in the next number of the *Journal,* described the appearance of the interstitial cells in various forms of mental disease and compared them with the normal at various ages and with one another, with special reference to dementia praecox. Dr. L. Pierce Clark contributed a study of the unconscious motivations in suicides, and Dr. Gregory Stragnell a paper entitled *Psychopatho-*

logical Disturbances from Avoidance of Parental Responsibility, based upon an analysis of the psychopathological problem involved in four recent plays—*Liliom, A Bill of Divorcement, Mary Rose,* and *Anna Christie.* Among the other articles of interest were *Folie à Deux,* by Dr. John H. W. Rhein; *Notes on a New Treatment for Mongolian Idiocy,* by Dr. William N. Berkeley; and *The Origin and Scope of the Modern State Hospital,* by Dr. Clarence A. Bonner.

The editorials include one on a recent article by William McDougall, *The Use and Abuse of Instincts in Social Psychology;* one on Freud's *Traum und Telepathie;* and a very sympathetic discussion of Nelson Antrim Crawford's *Mental Health and the Newspaper,* which appeared in the April number of MENTAL HYGIENE. The Wisconsin mental-deficiency survey and the relation between the sympathetic nervous system and the endocrine glands were other subjects discussed.

The book-review section was largely devoted to reviews of books in the field of neuropsychiatry.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

The annual meeting of the American Occupational Therapy Association was held at Atlantic City the last week in September. The association met in conjunction with the meeting of the American Hospital Association. There was an excellent program and probably the best exhibit of occupational-therapy work that has been held in this country. The following were elected officers for the coming year: President, T. B. Kidner, National Tuberculosis Association, New York City; Vice-president, Dr. G. Canby Robinson, Johns Hopkins Hospital, Baltimore; Secretary-Treasurer, Mrs. Eleanor Clarke Slagle, Director of Occupational Therapy, New York State Hospital Commission, Albany.

THE CALIFORNIA SOCIETY FOR MENTAL HYGIENE

During the past year the California Society for Mental Hygiene, under the leadership of its president, Dr. Harold Wright, has devoted itself to educational propaganda on the subject of the need for psychopathic wards in the San Francisco Hospital and other general hospitals. Meetings were held with the San Francisco Board of Health and the supervisors of the city and county, and in January a public meeting was called for full discussion of the subject, representatives of many civic organizations being invited to express their views. Publicity was obtained through one of the newspapers also. The San Francisco Hospital has the space for these psychopathic wards

and has had since it was built, but no appropriation for opening them has yet been made.

The society has also held meetings on the subjects of psychiatric clinics and the relation of crime to mental disease. Two lectures on mental conditions in childhood were given at the summer session of the California Teachers College, one by Dr. Wright and one by Dr. Eva C. Reid, and Dr. Wright gave a further course of lectures at Teachers College on feeblemindedness, psychopathic hospitals, early manifestations of mental disease, some aspects of psychoanalysis, and the psychiatric viewpoint on crime and delinquency.

During the coming winter the society plans to work for the amendment of the present insanity laws of California with the object of doing away with some of the cumbersome legal formalities attending admission to psychopathic hospitals, making them more easy of access for patients and their relatives.

A Postgraduate School of Neurology and Psychiatry

Under the title of the Postgraduate School of Neurology and Psychiatry of the District of Columbia, a school for the graduate teaching of diseases of the nervous system has been recently organized in Washington and opened formally in October. Dr. William A. White, Superintendent of St. Elizabeth's Hospital, is President of the institution; Dr. Tom A. Williams, Vice-president; Dr. Daniel D. V. Stuart, Jr., Secretary-Treasurer; and Dr. D. Percy Hickling, Dean of the Faculty. Two courses of study, elementary and advanced, of six weeks each are to be offered, together with an elective course in special subjects.

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Compiled by

DOROTHY E. MORRISON

The National Committee for Mental Hygiene

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INDEX OF AUTHORS AND SUBJECTS

A

Abstracts, 157–65, 396–402, 607–18, 827–37
Affective disturbances, 39–56
Alabama legislation, 198, 650
Alcoholism, statistics, 378, 381–82, 384–91. *See also* Mental diseases, causes; Mental diseases, statistics.
American Association for the Study of the Feebleminded, 661–62
American Occupational Therapy Association, 888
American Psychiatric Association, annual meeting, 661
American Psychopathological Association, 662
American Red Cross, St. Paul chapter, 312–31
Archives of Occupational Therapy, 660
Arizona legislation, 198

B

Bailey, Pearce, 57, 370
Bailey, Pearce, 392–95
Beers, Clifford W., 654–55
Behavior, psychology of, 498–521. *See also* Mental defectives, personality
Bibliography, current, 218–21, 443–45, 666–69, 890–93
Bingham, Anne T., 539
Blanchard, Phyllis, 39, 498
Bond, Earl D., 522
Book reviews, 166–97, 403–31, 619–49, 838–77
British National Council for Mental Hygiene, 655–57
Brown, Sanger, II, 651
Bureau of War Risk Insurance, 317
Buzzard, E. Farquhar, 449

C

California legislation, 198
California Society for Mental Hygiene, 888–89
Canada notes, 439, 653
Case studies, 41–54, 109–21, 235–39, 346–49, 357–64, 496–97, 711–12, 722–28, 736–42, 748–68, 800–01, 804–05, 806–07
Chaffee, Albert Billings, 440–42
Clark, L. Pierce, 708
Clark, Martha Haskell, 156
Conduct. *See* Behavior
Connecticut legislation, 199, 432
Constitutional psychopathic personality, 29–30, 359–65, 374, 729–45
Cox, Channing, 203
Crawford, Nelson Antrim, 300

D

Delaware legislation, 199
Delinquency, causes, 301–03
  psychiatric examination, 208–10, 343–69, 539–74
Dementia praecox, statistics, 288–99. *See also* Mental diseases, statistics
District of Columbia legislation, 200, 433
Donohoe, Marie L., 306
Drug addiction, statistics, 378, 381–82, 385–91
Dualism, 673–87

E

Emerson, Charles P., 257
Emerson, Haven, 225
Emotions, 683. *See also* Affective disturbances; Laziness
Endocrinopathies, 374
  statistics, 378, 381–83, 385–87, 389, 391
Epilepsy, statistics, 378, 381–82, 385
Erie County, N. Y., institutions for orphaned, dependent and delinquent children, 780

F

Federal Board for Vocational Education, 320, 327, 328
Fernald, Walter E., 471
Florida legislation, 200, 650
Furbush, Edith M., 288

G

Georgia legislation, 200, 433
Goldberg, Jacob A., 598
Guiterman, Arthur, 826

H

Habit clinics, 463–70, 727
Haines, Thomas H., 83
Haviland, C. Floyd, 688
Hayes, Elizabeth C., 125
Healy, William, 248
Howe, Susanne, 826

I

Idaho legislation, notes, etc., 433, 650
Illinois notes, 433, 878
Illinois State Department of Public Welfare, Division of Alienist, *Bulletin*, 660–61
Indiana notes, 434
Individuality, 603–06
Internal secretions, 522–25
Iowa legislation, 200

J

Jewett, Stephen Perham, 39
Jews, 598–602. *See also* Race psychiatry
Journal of Personnel Research, 659

K

Kentucky Child Welfare Commission, 878
Kentucky legislation, 878
Kline, Lila, 93

L

Laziness, 68–82
Louisiana legislation, notes, etc., 200, 434, 878–79

M

Maryland legislation, 434
Massachusetts legislation, 201, 650–51, 879
Massachusetts Society for Mental Hygiene, *Bulletin*, 659–60
Massonneau, Grace, 575
Matthews, Mabel A., 332
Mental clinics, 471–86. *See also* Habit clinics; Psychiatric social work
Mental defectives, care and treatment, 57–67, 203–05, 332–42, 688–99
  education, 708–13. *See also* Mental defectives, care and treatment
  in industry, 332–42, 481, 526–38
  in military services, 373
  personality, 487–97
  statistics, 67, 377–91
  surveys, 206–07
Mental diseases, care and treatment, 744–45. *See also* Mental diseases in ex-service men; Psychiatric social work
  causes, 815–25. *See also* Mental diseases in ex-service men
  in ex-service men, 3–11, 23–38, 575–91
  in industry, 526–38
  prevention, 203–05
  statistics, 212, 288–99, 378–91, 598–602, 690–93, 732–35, 815–25. *See also* Dementia praecox, statistics
Mental hygiene 257–62, 449–62
  and children, 463–70, 471–86, 688–99, 746–72, 773–97
  and newspapers, 300–05
  and public health, 225–33
  societies and committees, directory of, 222, 446, 670, 894
  surveys, 746–72, 773–97, 882–86
Mental tests, 39–56
Michigan legislation, notes, etc., 201
Military neuropsychiatry, 216–17. *See also* Mental diseases in ex-service men
Minnesota notes, 434
Missouri legislation, notes, etc., 201, 435, 651, 879
Mott, Sir Frederick, 673

N

National Committee for Mental Hygiene, Thirteenth annual meeting, 216
  members and directors, 223–24, 447–48, 671–72, 895–96
National Conference of Social Work, Forty-ninth annual meeting, 439–40
National Education Association, Mental Hygiene Session, 662
National Home for Disabled Volunteer Soldiers, Southern branch, 205–06
National Research Council, 11
Nervous diseases, statistics, 374–75, 378, 381–82, 385–87
Nervousness, causes, 263–87
Neuroses, 234–47. *See also* Nervousness, causes.
Nevada legislation, 651
New Jersey legislation, 879
New York legislation, notes, etc., 435–36, 879–80
New York Medical Journal and Medical Record, Neuropsychiatric number, 887–88
New York Probation and Protective Association, 539–74
Nixon, Charles E., 603
North Carolina notes, 201, 436, 651
North Dakota legislation, 436
Notes and comments, 198–217, 432–42, 650–65, 878–89

O

Occupational therapy, 35
Ohio legislation, 436–37, 652
Oklahoma legislation, 652

P

Parole, 332–42, 798–814. *See also* Psychiatric social work

Pennsylvania Department of Public Welfare, Bureau of Mental Health, 886–87
Pennsylvania legislation, notes, etc., 201–02, 437, 652
Physiotherapy, 34
Poems, 156, 826
Pollock, Horatio M., 592, 815
Postgraduate School of Neurology and Psychiatry, 889
Potter, Howard W., 487
Pratt, George K., 526
Psychiatric social work, 93–124, 125–55, 210–12, 306–11, 312–31, 714–28
Psychiatry, 248–56
Psychoanalysis, 450–51
Psychology, 83–92, 248–56, 498–521, 700–07
"clinical," 11–22
Psychoneuroses, 25–27, 374, 575–91
statistics, 378, 381–82, 385–88
Psychotherapy, 451–52

R

Race psychiatry, 370–91
Rhode Island legislation, 880
Riggs, Austen Fox, 263
Rosanoff, Aaron J., 773

S

Salmon, Thomas W., 1
Sands, Irving J., 498
Scott, Augusta, 343
Sex offenses, 346, 348–64
Singer, H. Douglas, 23
Slagle, Mrs. Eleanor Clarke, 879
South Carolina legislation, 437–38, 880
State hospitals, personnel, 592–97
Steckel, Harry A., 798

T

Taylor, Marianna, 746
Texas notes, 202
Thom, Douglas A., 23, 234, 463, 714

U

U. S. Veterans' Bureau, 3, 4, 7, 663–64

V

Venereal diseases, 213–15
Vermont legislation, 738
Virginia legislation, notes, etc., 652–53, 880–82
Visher, John W., 729
Vocational training, 35–36

W

Wells, F. L., 11, 700
West Virginia legislation, notes, etc., 438–39, 653
Wile, Ira S., 68
Williams, Frankwood E., 653–54
Wisconsin notes, 202
Worch, Margaret, 312
Wyoming legislation, 202

ABSTRACTS AND REVIEWS

Listed by Authors of Books and Articles

Adams, Elizabeth Kemper. Women professional workers. Rev. by E. M. Furbush. 619.

American Association for the Study of the Feebleminded. Proceedings and addresses of the 45th annual session, May 28, 29, 30, 31, 1921. Rev. by H. A. Haynes. 636.

Andrews, Lincoln C. Man-power. Rev. by M. W. Peck. 421.

Arnold-Foster, Mary. Studies in dreams. Rev. by L. P. Clark. 419.

Bassoe, Peter. Problems confronting the section of nervous and mental diseases. 827.

Beers, Clifford Whittingham. A mind that found itself. Rev. by L. F. Barker. 166.

Bergson, Henri. Mind-energy; lectures and essays. Rev. by M. C. Otto. 186.

Berman, Louis. The glands regulating personality; a study of the glands of internal secretion in relation to the types of human nature. 410.

Björkman, Edwin. The soul of a child. Rev. by F. E. Williams. 639.

Blaisdell, Russell E. What patients may safely be paroled. 834.

Briggs, L. Vernon. The manner of man that kills. Rev. by J. R. Oliver. 170.

Briggs, L. Vernon. Mental hygiene in its relation to present-day nursing. 832.

Brill, A. A. Fundamental conceptions of psychoanalysis. Rev. by F. J. Farnell. 859.

Brown, William, and Godfrey H. Thomson. Essentials of mental measurement. Rev. by Donald Slesinger. 636.

Burr, C. B. Practical psychology and psychiatry: for use in training schools for attendants and nurses and in medical classes, and as a ready reference for the practitioner. Rev. by E. D. Bond. 196.

Bundy, Walter E. The psychic health of Jesus. 877.

Butler, George F. How the mind cures. Rev. by W. B. Terhune. 429.

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Cameron, Edward Herbert. Psychology and the school. Rev. by E. R. Groves. 430.

Casamajor, Louis. Neuroses in business life. 160.

Chapin, F. Stuart. Field work and social research. Rev. by K. M. Gould. 637.

Chapman, J. Crosby. Trade tests: the scientific measurement of trade proficiency. Rev. by K. M. Gould. 416.

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Coué, Émile. Self-mastery through conscious auto-suggestion. 876.

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Drever, James. The psychology of everyday life. Rev. by F. E. Williams. 194.

Drever, James. The psychology of industry. Rev. by F. E. Williams. 194.

Duclaux, Emile. Pasteur; the history of a mind. Rev. by F. E. Williams. 629.

Edman, Irwin. Human traits and their social significance. Rev. by F. J. Farnell. 641.

Emerson, William R. P. Nutrition and growth in children. Rev. by Florence Meredith. 864.

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Ferenczi, S., Karl Abraham, Ernst Simmel and Ernest Jones. Psychoanalysis and the war neuroses. Rev. by Milton A. Harrington. 852.

Forsyth, David. The technique of psychoanalysis. 877.

Freud, Sigmund. Dream psychology, psychoanalysis for beginners. Rev. by Bernard Glueck. 184.

Gesell, Arnold. Exceptional children and public school policy. Rev. by W. H. Burnham. 424.

Goddard, Henry H. Juvenile delinquency. Rev. by K. M. Bowman. 421.

Gut, Walter. Von Seelischen Gleichgewicht und Seinen Störungen. Rev. by Bernard Glueck. 423.

Hall, G. Stanley. Aspects of child life and education. Rev. by F. E. Williams. 646.

Harrison, Elizabeth. Misunderstood children; sketches taken from life. Rev. by A. T. Bingham, 642.

Harrison, Elizabeth. When children err; a book for young mothers. Rev. by A. T. Bingham. 642.

Healy, William. Study of the case preliminary to treatment. 828.

Hollingworth, Leta S. The psychology of subnormal children. Rev. by Smiley Blanton. 168.

Hoch, August. Benign stupors. Rev. by Sanger Brown, II. 850.

Holmes, Samuel J. The trend of the race. Rev. by Abraham Myerson. 628.

Hoyt, Franklin Chase. Quicksands of youth. Rev. by A. F. Bronner. 181.

Huckel, Oliver. The habit of health. Rev. by F. J. Farnell. 647.

Jackson, Josephine A., and Helen M. Salsbury. Outwitting our nerves. Rev. by H. N. Kerns. 184.

Jones, Edith Kathleen. The library in the mental hospital. 836.

Kelley, E. R. Two twilight zones in health administration. 830.

Kirby, George H. Guides for history taking and clinical examination of psychiatric cases. Rev. by E. D. Bond. 619.

Kleinschmidt, H. E. Medical services money cannot buy. 837.

Knowlson, T. Sharper. The art of thinking. Rev. by F. J. Farnell. 647.

Korzybski, Alfred. The manhood of humanity: the science and art of human engineering. Rev. by F. E. Williams. 172.

Laird, Donald A. What the state demands of its sentinels of mental health. 157.

Lange, Carl Georg, and William James. The emotions. Rev. by S. M. Shellow. 872.

Larson, Christian D. Practical self-help. Rev. by F. J. Farnell. 647.

Lawrence, D. H. Psychoanalysis and the unconscious. Rev. by J. T. MacCurdy. 176.

Lay, Wilfrid. Man's unconscious spirit: the psychoanalysis of spiritism. Rev. by C. O. Cheney. 633.

Le Bon, Gustave. The world in revolt; a psychological study of our times. Rev. by W. A. White. 403.

Lomax, Montagu. The experiences of an asylum doctor, with suggestions for asylum and lunacy law reform. Rev. by J. V. May. 182.

Macearthy, Francis Hamilton. The healthy child from two to seven. Rev. by Florence Meredith. 869.

Macdonald, John B. Social service and out-patient relations. 611.

McDougall, William. The nature of functional disease. 607.

May, James V. Mental diseases: a public health problem. Rev. by A. M. Barrett. 846.

Meggendorfer, Frederick. Klinische und Genealogische Untersuchungen über "Moral Insanity." 163.

Miller, H. Crichton. The new psychology and the teacher. Rev. by F. E. Williams. 413.

Milnes, Nora. Child welfare from the social point of view. Rev. by T. H. Ames. 426.

Mitchell, Lucy Sprague. Here and now story book. Rev. by K. M. Bowman. 631.

Munson, Edward L. The management of men. Rev. by F. L. Wells. 406.

Muscio, Bernard. Lectures on industrial psychology. Rev. by M. C. Gould. 191.

Monroe, Walter S. Report of Division of educational tests for 1919–1920. Rev. by Smiley Blanton. 648.

Myers, Charles S. Mind and work; the psychological factors in industry and commerce. Rev. by Abraham Myerson. 628.

Newman, Horatio Hackett. Readings in evolution, genetics and eugenics. Rev. by Bernard Glueck. 423.

O'Shea, M. V. Mental development and education. Rev. by E. R. Groves. 429.

Paton, Stewart. Human behavior in relation to the study of educational, social, and ethical problems. Rev. by L. P. Clark. 167.

Payot, Jules. Will power and work. Rev. by W. B. Terhune. 428.

Platt, Charles. The psychology of thought and feeling. Rev. by M. E. Kenworthy. 645.

Pollock, Horatio M. Criminal records and statistics. 616.

Pollock, Horatio M. Mental disease in cities, villages, and rural districts of New York State. 396.

Porter, Mary F. Applied psychology for nurses. Rev. by E. D. Bond. 430.

Raynor, Mortimer W. Organization of social work in a state hospital. 833.

Read, Charles F. A habit training school for the mentally deteriorated. 398.

Richmond, Mary E. What is social case work? Rev. by F. E. Williams. 622.

Robinson, David. Control of venereally diseased persons in interstate commerce. 401.

Robinson, Louis N. Penology in the United States. Rev. by E. R. Cass. 870.

Rostrevor, George. Bergson and future philosophy; an essay on the scope of intelligence. Rev. by M. C. Otto. 188.

Russell, Bertrand. The analysis of mind. Rev. by S. E. Jelliffe. 404.

Saleeby, C. W. The eugenic prospect: national and racial. Rev. by A. Myerson. 408.

Slagle, Eleanor Clarke. Training aids for mental patients. 614.

Society of the New York Hospital. A psychiatric milestone; Bloomingdale hospital centenary. 874.

Society of the New York Hospital, 1771–1921. Commemorative exercises, 150th anniversary. 875.

Southard, E. E., and Mary C. Jarrett. Kingdom of evils; psychiatric social work presented in one hundred case histories together with a classification of social divisions of evil. Rev. by Abraham Myerson. 838.

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Williams, J. Harold. Whittier social case history manual. Rev. by A. F. Bronner. 868.

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